State of Missouri
Quality Improvement Strategy
(QIS)
Medicaid Managed Care Program
2010

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MO HealthNet Division (Missouri Medicaid)
Managed Care Unit

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Revision

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A. History of the MO HealthNet Program

MO HealthNet Fee-For-Service (FFS) Program

The Medicaid Program, authorized by federal legislation in 1965, provides health care access to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children. Since that time, legislative options and mandates have expanded the categories of eligibility to include Medicaid coverage for children and pregnant women in poverty, refugees, and children in state care. The Missouri Medicaid program is jointly financed by the federal government and Missouri State Government, and is administered by the State of Missouri. The agency charged with administration of the Medicaid program is the MO HealthNet Division, a division within the Department of Social Services.

Missouri's commitment to providing health care for the indigent predates the federal enabling legislation. In 1959, a limited medical assistance program began. Coverage was limited to inpatient hospital care with a maximum reimbursement rate of $5.00 per day. Benefits were limited to 100 days per patient per year. In 1963, due to opportunities afforded by federal law, Missouri implemented limited prescription drug and dental programs for the adult assistance categories. At that time, these were the only programs for which federal funds could be claimed.

In October 1967, the 74th Missouri General Assembly enacted legislation establishing a medical services program under the provision of Title XIX of the Social Security Act. The program established was the Missouri Medicaid Program. When Missouri's Title XIX, or "Medicaid" Program was implemented, the new services covered by the program included outpatient hospital care, physicians' services, and professional nursing home care. Implementation also provided first time coverage to the blind; permanently and totally disabled recipients; and greatly expanded services to Aid to Families with Dependent Children.

The state also has a limited medical assistance program, which is funded with General Revenue and Blind Pension funds. The program allows Child Welfare Services (CWS) recipients and Blind Pension recipients who are not eligible for the federal Medicaid program to receive necessary medical care.

The Personal Responsibility Work Opportunity Reconciliation Act of 1996 (PRWORA) was signed into law on August 22, 1996. (PL 104-193)

The bill was a comprehensive piece of legislation that created Temporary Assistance for Needy Families (TANF), which replaced the entitlement program of Aid to Families with Dependent Children (AFDC). This legislation severed the automatic link between eligibility for cash assistance and the receipt of Medicaid. Families may continue to be

eligible for Medicaid through Medical Assistance for Families (MAF), but Medicaid eligibility is no longer guaranteed for those families receiving cash assistance.
On September 1, 2005, the 93rd Missouri General Assembly enacted legislation that reduced optional Medicaid services provided to adults, unless the individual is receiving benefits under a category of assistance for pregnant women or the blind.

With passage of the Missouri Health Improvement Act of 2007 (SB 577) by Missouri's 94th General Assembly session, the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42U.S.C. Section 301 et seq., shall be known in the state of Missouri as MO HealthNet. In addition to Medicaid being referred to as MO HealthNet the title "Division of Medical Services" is now referred to as "MO HealthNet Division". This change became effective September 1, 2007.

Medicaid Waivers
Congress enacted Section 2176 of Public Law 97-35 of the Social Security Act, entitled the Omnibus Budget Reconciliation Act. Through this enactment in 1981, certain statutory limitations have been waived in order to give states, who have received approval from the Department of Health and Human Services, the opportunity for innovation in providing home and community based services to eligible persons who would otherwise require institutionalization in a nursing facility, hospital or intermediate care facility for the mentally retarded (ICF/MR). Currently, Missouri has approval to provide services under the following waivers:

- ***Aged and Disabled Waiver:*** This program offers in-home services to individuals aged 63 or over who have been assessed to certain impairments and unmet needs to the extent that they would require nursing home care in the absence of these services. The services available include homemaker/chore, respite, home delivered meals, and adult day care. The Department of Health and Senior Services, Division of Senior and Disability Services administers this program.

- ***AIDS Waiver:*** This program provides in-home services to participants diagnosed by a physician as having AIDS or an HIV-related illness and is assessed as meeting a nursing home level of care. The services available include personal care, private duty nursing, attendant care, and supplies. The Department of Health and Senior Services, Bureau of HIV, STD, and Hepatitis administers this program.

- ***Independent Living Waiver:*** This program is similar to the Consumer-Directed State Plan Personal Care program, requiring the same eligibility criteria be met and offering additional personal assistance services beyond the limitations of the state plan. Additional services available include environmental accessibility adaptations, specialized medical equipment and supplies, and case management. The Department of Health and Senior Services, Division of Senior and Disability Services administers this program.

- ***Developmental Disabilities Comprehensive Waiver (DD):*** This program offers services to individuals who have mental retardation and/or a developmental disability,

who would, except for receipt of services through this program, require placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The services available through this program include residential and day habilitation, individualized support living, behavioral/physical/occupational/speech therapy, in and out of home respite, personal assistant, community specialist, counseling and crisis intervention, communication skills instruction, supported employment, transportation, environmental accessibility adaptations, specialized medical equipment and supplies, and support broker services. The Department of Mental Health, Division of Mental Retardation and Developmental Disabilities administer this program.

- ***Missouri Children with Developmental Disabilities Waiver:*** *(MOCDD:* Also known as the Sarah Lopez Waiver was implemented October 1, 1995. The waiver grants Medicaid eligibility to those children who would be determined eligible for MO HealthNet if they were to reside in an institution, but whose families have chosen to have the child remain home. The MOCDD waiver permits the state to view only the child's income when making the eligibility determination. Services provided through the MOCDD waiver mirror those provided through the MR/DD waiver with the exception of residential services.

- ***Developmental Disabilities Community Support Waiver:*** This waiver is targeted to individuals who have a place to live in the community and receive substantial unpaid support from family members. The eligibility criteria and services available through this program are identical to the MR/DD waiver program with the exception of residential habilitation and individualized supported living. The Department of Mental Health, Division of Mental Retardation and Developmental Disabilities administer this program.

- ***Managed Care (1915(b)) Waiver:*** Provides health care services for MO HealthNet beneficiaries through a Managed Care delivery system. All MO HealthNet beneficiaries are required to enroll in Managed Care except individuals who are in the Managed Care Program either because they receive SSI disability payments, they meet the SSI disability definition as determined by the Department of Social Services, or they receive adoption subsidy benefits. These individuals have the option of choosing to receive health care services on a fee-for-service basis or through the Managed Care program. The option is entirely up to the individual, parent, or guardian. Those individuals not residing in a Managed Care county receive their health care services on a fee-for-service basis.

- ***Women's Health Services Program (1115 Demonstration Waiver):*** Missouri's Women's Health Services Program expands MO HealthNet coverage to uninsured women (Sixth Omnibus Reconciliation Act (SOBRA 1986) women) who are 18 to 55 years of age losing their MO HealthNet eligibility 60 days after the birth of their child. These women are eligible for women's health services for a maximum of one year after their MO HealthNet eligibility expires. Eligibility is automatically extended from the current 60-day postpartum period for this eligible population. There is no cost sharing for this coverage and services are obtained through the MO HealthNet Fee-For-Service program.

- ***Physical Disabilities Waiver:*** This program offers services to individuals who have serious and complex medical needs and are no longer eligible for services under the Healthy Children and Youth program. To be eligible, an individual must be age 21 or older and assessed as requiring placement in an ICF/MR absent these services. The services available include attendant care, private duty nursing and specialized medical equipment/supplies. The Department of Health and Senior Services, Bureau of Special Health Care Needs administers this program.

MO HealthNet Managed Care Program

Medicaid Managed Care for AFDC Participants (Jackson County Only)
In July 1982, Missouri received a four year federal demonstration grant to implement a managed health care program for Aid to Families with Dependent Children (AFDC) participants in Jackson County. Enrollment into the program began January 1984 with full enrollment achieved in the first quarter of 1985. The original demonstration grant was extended to December 31, 1986, at which time the established program began operating under a waiver issued by the authority of Section 1915(b) of the Social Security Act and enrollment was mandatory. The goal of the program was to furnish improved quality, continuity, and accessibility of health care services to enrollees, while providing the State with significant cost savings.

This Managed Care Program was a health care delivery system for AFDC participants where primary care services were provided by four prepaid health plans and approximately thirty individual physicians, called physician sponsors. The four prepaid health plans were reimbursed on a capitated basis and the physician sponsors were reimbursed on a fee-for-service basis. Each AFDC participant chose either a health plan or a physician sponsor, who was responsible for coordinating the health care provided to the participant. Medical services offered under the Missouri Medicaid Program were also available to managed health care enrollees; however, the majority of these services were either obtained through or referred by the chosen health plan or physician sponsor.

Managed Care Program

In 1995, Missouri requested and received approval to implement a managed care program, Managed Care, in the Eastern Region of the State. Waiver authority was granted under Section 1915(b) of the Social Security Act for Managed Care Organizations (MCOs) to provide contracted services to certain targeted groups of Medicaid eligibles. The mandatory target groups included MO HealthNet for Families (MHF), formerly known as Temporary Assistance for Needy Families (TANF), MO HealthNet for Pregnant Women and Newborns, formerly known as Medicaid for Pregnant Women (MPW), Refugees, MO HealthNet for Kids (MHK), formerly known as Medicaid for Children, and Children in State Care and Custody. MO HealthNet eligibles in the targeted groups who receive Supplemental Security Income (SSI) or who meet the medical definition for SSI may choose not to enroll or voluntarily disenroll from the Managed Care Program at anytime.

Population exclusions include:

- Individuals dually eligible for Medicare and Medicaid.
- Individuals in long-term care facilities.
- Individuals who participate in a Home and Community Based Waiver.
- Individuals eligible for Aid to the Blind and Blind Pension.
- Permanently and Totally Disabled individuals.
- Pregnant women eligible for the Presumptive Eligibility Program.
- Individuals eligible under Presumptive Eligibility for Children.
- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible for women's health services for one year plus 60 days, regardless of income level. This population will obtain their services through the MO HealthNet Fee-For-Service Program.
- Breast and Cervical Cancer Control Project (BCCCP) participants.
- Individuals eligible under Voluntary Placement Agreement for Children.
- Children placed in foster homes or residential care by the Department of Mental Health.
- AIDS Waiver participants.
- Individuals eligible under MO Children with Developmental Disabilities Waiver.
- Individuals eligible under Qualified Medicare Beneficiary – QMB.
- Children placed in residential care by their parents, if eligible for MO HealthNet on the date of placement.
- Individuals under the Temporary Assignment Category.
- Individuals eligible under MORx.

Missouri's Waiver Program is authorized under Section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, Missouri is relying upon authority provided in the following subsections of section 1915(b):

1. 1915(b) (1) – Requires enrollees to obtain medical care through specialty physician services arrangements.
2. 1915(b)(2) – A locality will act as a central broker in assisting eligible individuals in choosing among competing MCOs in order to provide enrollees with more information about the range of health care options open to them.
3. 1915(b)(4) – Requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards consistent with access, quality and efficient and economic provision of covered care and services.

Missouri waives the following sections of 1902 of the Act:

1. 1902(a)(1) – Statewideness,
2. 1902(a)(10)(B) -Comparability of Services, and
3. 1902(a) (23) – Freedom of Choice.

Eastern Region: Beginning in September 1995, the following seven MCOs, HealthCare USA, Care Partners, Mercy Health Plans, Community Care Plus, Prudential Health Care,

Humana, and GenCare, served approximately 150,000 enrollees. The Eastern Region included the counties of St. Louis, St. Charles, Jefferson, and Franklin and St. Louis City. Two of the original MCOs (GenCare and Humana) withdrew in 1997. February 1, 2000, HealthCare USA purchased Prudential's Medicaid business. Prudential enrollees were given an opportunity to choose a participating MCO other than Prudential.

Effective December 1, 2000, the counties of Lincoln, St. Francois, Ste. Genevieve, Warren, and Washington were included in the Eastern Region. The following changes were made to the benefit package: Mentally Retarded and Developmentally Disabled (MRDD) participants and participants with Third Party Liability (TPL) were no longer carved out; any adoption subsidy child could opt out; reinsurance was excluded; and the 30/20 limitation on mental health services was eliminated.

Care Partners chose not to rebid its contract that terminated December 31, 2002. The following MCOs served Managed Care enrollees in the Eastern Region until June 30, 2006: Community CarePlus, HealthCare USA, and Mercy MC+.

Effective July 1, 2006, Community CarePlus' ownership changed to include Mercy Health Plans. Mercy MC+ was eliminated and Community CarePlus became known as Mercy CarePlus.

Effective January 1, 2008, the State of Missouri introduced the Managed Care Program in Madison, Perry, and Pike counties. These three counties are included in the current Eastern Region. The State anticipated that approximately 4,745 individuals would enroll in the Managed Care Program in the Eastern Region as result of the expansion.

Effective October 1, 2008, Mercy CarePlus was renamed Molina Healthcare of Missouri. The following MCOs currently serve Managed Care enrollees in the Eastern Region: Harmony Health Plan of Missouri, HealthCare USA, Missouri Care Health Plan, and Molina Healthcare of Missouri.

Central Region: Missouri received waiver modification approval to expand the Managed Care Program to the Central Region in March 1996. HealthCare USA, GenCare, and Blue Choice were operational in the following eighteen counties: Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Randolph, and Saline. In February 1998, GenCare and Blue Choice were no longer participating MCOs. They chose not to rebid their contracts. Effective March 1, 1998, the participating MCOs were Care Partners, HealthCare USA, and Missouri Care. There was no change in the counties served.

Contracts were rebid effective March 1, 2001. Participating MCOs were Missouri Care and HealthCare USA. Care Partners chose not to rebid its contract. The following changes were made to the benefit package: MRDD participants were no longer carved out; any adoption subsidy child could opt out; reinsurance was offered through the State but MCOs opted to purchase from an outside entity; and the 30/20 limitation on the mental health services was eliminated.

The following MCOs served Managed Care enrollees in the Central Region until June 30, 2006: Community CarePlus, HealthCare USA and Missouri Care. Effective July 1, 2006, Community CarePlus' ownership changed to include Mercy Health Plans. Mercy MC+ was eliminated and Community CarePlus became known as Mercy CarePlus.

Effective January 1, 2008, the State of Missouri introduced the Managed Care Program in Benton, Laclede, Linn, Macon, Maries, Marion, Phelps, Pulaski, Ralls, and Shelby counties. These ten counties were included in the current Central Region. The State anticipated that approximately 23,636 individuals would enroll in the Managed Care Program as a result of the expansion in the Central Region.

Effective October 1, 2008, Mercy CarePlus was renamed Molina Healthcare of Missouri. The following MCOs currently serve Managed Care enrollees in the Central Region: HealthCare USA, Molina Healthcare of Missouri, and Missouri Care Health Plan.

Western and Northwestern Regions: An additional waiver modification was requested and approved to expand the Managed Care Program to the Western and Northwestern regions of the state in January 1997. This expansion replaced the Medicaid Managed Care Program for AFDC participants in Jackson County that was implemented in January 1984.

Western Region: The Western Region originally consisted of Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray counties. Participating MCOs were HealthNet, Family Health Partners, FirstGuard, and Blue Advantage Plus.

In February 1999, the service area was expanded to include Henry and St. Clair counties with the MCOs remaining the same. The MRDD population was included as an eligible group. Reinsurance was no longer offered as an option and MCOs were required to purchase reinsurance from an outside entity.

HealthNet chose not to rebid its managed care contract, which terminated January 31, 2002. The following MCOs served Managed Care enrollees in the Western Region: Blue-Advantage Plus of Kansas City, Family Health Partners, FirstGuard Health Plan, and HealthCare USA.

The following MCOs currently serve Managed Care enrollees in the Western Region: Blue-Advantage Plus of Kansas City, Children's Mercy Family Health Partners, HealthCare USA, Molina Healthcare of Missouri, and Missouri Care Health Plan.

Effective July 1, 2006, Community CarePlus' ownership changed to include Mercy Health Plans. Mercy MC+ was eliminated and Community CarePlus became known as Mercy CarePlus. The following MCOs served the Managed Care enrollees in the Western Region: Blue-Advantage Plus of Kansas City, Children's Mercy Family Health Partners, FirstGuard Health Plan, and HealthCare USA.

Effective July 1, 2006, Children's Mercy Family Health Partners transitioned the management of pharmacy to MO HealthNet.

Effective February 1, 2007, HealthCare USA purchased FirstGuard Health Plan's Medicaid business.

Effective January 1, 2008, the State of Missouri introduced the Managed Care Program in Bates, Cedar, Polk, and Vernon counties. These four counties were included in the current Western Region. The State anticipated that approximately 9,200 individuals would enroll in the Managed Care Program as a result of the expansion in the Western Region.

Blue-Advantage Plus chose not to bid in the four expansion counties and served Managed Care enrollees in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, and St. Clair counties. Effective July 1, 2008, Blue –Advantage Plus of Kansas City transitioned the management of pharmacy to MO HealthNet.

Northwestern Region: The Northwestern region was composed of Andrew, Atchison, Buchanan, Caldwell, Carroll, Clinton, Davies, DeKalb, Gentry, Grundy, Harrison, Holt, Livingston, Mercer, Nodaway, and Worth counties. Blue Advantage Plus and Community Health Plan chose not to contract with the State and all enrollees reverted back to fee-for-service on December 1, 1998.

Managed Care Program Changes

During December 2001, uninsured custodial parents below 100% of the Federal poverty level under the 1115 waiver were transitioned to eligibility under Section 1931 with coverage under the 1915(b) Waiver population, with an effective date of January 1, 2002. Between 2002 through 2005, budget actions lowered the eligibility standards at which time coverage ended for this group of uninsured parents.

Effective July 1, 2002, the following changes to the Managed Care Program resulted from passage of House Bill 1111 during Missouri's 91st General Assembly legislative session:

- Dental services for participants age 21 and over were limited to the treatment of trauma to the mouth or teeth as a result of injury and dentures.
- Eyeglasses for adults only following cataract surgery, and
- Coverage for circumcisions was limited to medical necessity only.

Coverage of dental services for participants age 21 and over that were eliminated were restored for adults on August 21, 2002 and coverage of prescription eyeglasses for Medicaid eligible adults were restored effective February 24, 2003 as a result of preliminary injunction court orders. This benefit remains carved out of the MO HealthNet Managed Care comprehensive benefit package and is covered by the MO HealthNet Fee-For-Service program.

Effective September 1, 2005, the following changes to the Managed Care Program occurred as a result of passage of Senate Bill 539 during Missouri's 93rd General Assembly legislative session:

- Dental services for participants age 21 and over (except for pregnant women in ME codes 18, 43, 44, 45, and 61) were limited to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury. Services for the treatment of a medical condition without which the health of the participant would be adversely affected were carved out of the Managed Care comprehensive benefit package and covered through the Fee-For-Service Program.
- Dental services for pregnant women were limited to dentures and services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury. Services to prepare the mouth for dentures, such as examinations, X-rays, or extractions; ancillary denture services such as relining, rebasing, and repairs; and all other Medicaid State Plan dental services for pregnant women were covered through the Fee-For-Service Program.
- Certain podiatry services were eliminated (procedure codes 11719, 11720, 11721, 11750, and 29540) for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61),
- Optometric services for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61) were limited to one eye examination every 2 years.
- Comprehensive day rehabilitation services for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61) were eliminated; and
- Durable medical equipment (DME) was limited to prosthetic devices; respiratory equipment and oxygen, with the exception of CPAP, BiPAP, and nebulizers; wheelchairs; diabetic supplies and equipment; and ostomy supplies for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61). Regardless of age, participants with a home health plan of care receive DME services for the duration of their home health plan of care.

Effective July 1, 2006, the following changes to the Managed Care Program occurred as a result of passage of House Bill 1011 during Missouri's 93rd General Assembly 2006 legislative session:

- Optometric services for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61) were limited to eye examinations and one pair of eyeglasses following cataract surgery.
- Durable medical equipment (DME) was limited to prosthetic devices; respiratory equipment and oxygen, with the exception of CPAP, BiPAP, and nebulizers; wheelchairs (including batteries and accessories); diabetic supplies and equipment; and ostomy supplies for participants age 21 and over (except for pregnant women in ME Codes 18, 43, 44, 45, and 61). Regardless of age, participants with a home health plan of care receive DME services for the duration of their home health plan of care.

Effective July 1, 2007, individuals who were independent foster care adolescents, age 18 to 21, became eligible for coverage without regard to income or assets. These individuals had the opportunity to enroll in an MCO in areas of the State served by the Managed Care Program. In areas of the State where MCOs were not operational, these individuals received benefits from the MO HealthNet Fee-For-Service Program. These individuals received all services specified in the comprehensive benefit package for children in State care and custody less than 21 years of age. This change extended coverage to

approximately 970 individuals. The State anticipated that approximately 175 individuals were eligible for coverage under the Managed Care Program.

As result of passage of House Bill 11 during Missouri's 94th General Assembly 2007 legislative session, the Missouri General Assembly approved a statutory change for the MO HealthNet Division to develop a four-year plan to achieve parity with Medicare reimbursement rates for all providers. Effective July 1, 2007, physician reimbursement rates that were less than 55% of the Medicare reimbursement rate were increased to 55%, physician reimbursement rates at 55% were unchanged, and physician reimbursement rates more than 55% were increased by 10%.

Effective September 1, 2007, the following changes to the Managed Care Program occurred as a result of passage of Senate Bill 577 during Missouri's 94th General Assembly 2007 legislative session:

- The medical assistance program on behalf of needy persons became known as MO HealthNet and the title "Division of Medical Services" became MO HealthNet Division (MHD). Medicaid also meant MO HealthNet.
- The MCOs were responsible for providing DME services for adults (including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, and diabetic supplies and equipment.

Effective October 1, 2008, Mercy CarePlus was renamed Molina Healthcare of Missouri.

Effective October 1, 2009, dental and optical services for adults were no longer carved out of the Managed Care comprehensive benefit package.

Effective October 1, 2009, pharmacy services were carved out of the Managed Care comprehensive benefit package and covered by the MO HealthNet Fee-For-Service Program.

Presumptive Eligibility for Children

In 2005 Missouri began to provide presumptive eligibility for children in families with income of 150% of FPL or below until a decision is made on regular MO HealthNet for Kids Program eligibility. Uninsured children age one through age five with family income more than 133% of the Federal Poverty Level (FPL) but less than 151% of the FPL, and uninsured children ages 6 through 18 with family income more than 100% of the FPL but less than 151% of the FPL are covered under the CHIP Expansion Program.

Children eligible for the CHIP Expansion Program receive the MO HealthNet package of essential medically necessary health services, including Non-Emergency Medical Transportation (NEMT). Prescription drugs are subject to the national drug rebate program requirements. Fee-For-Service is utilized in regions where Managed Care is not available. When Managed Care begins in these areas, Title XXI eligibles will be enrolled in Managed Care. No new eligible is excluded because of pre-existing illness or condition.

Children's Health Insurance Program (CHIP)

Missouri's Children's Health Insurance Program (CHIP) was a Medicaid expansion implemented on September 1, 1998 through a waiver under Section 1115 of the Social Security Act and a Title XXI Plan that covered children under the age of 19 in families with a gross income of 300 percent of the Federal poverty level (FPL). Coverage was provided through the Managed Care delivery system in areas of the State covered by the Section 1915(b) waiver and through the MO HealthNet Fee-For-Service Program in the remainder of the State. Uninsured women losing their MO HealthNet eligibility sixty (60) days after the birth of their child were covered for women's health services for an additional year, regardless of their income level. This population receives services through the MO HealthNet Fee-For-Service Program.

Effective September 1, 2007 the CHIP Program transitioned to a combination CHIP State Plan and the Women's Health Services Program transitioned to the Missouri Women's Health Services Program Section 1115(a) Demonstration Waiver.

Combination State Children's Health Insurance Program

Effective September 1, 2007 the Centers for Medicare and Medicaid Services (CMS) approved Missouri's request for a combination Children's Health Insurance Program (CHIP). The CHIP combination program is comprised of a MO HealthNet Expansion and a Separate Child Health Program.

MO HealthNet for Kids Program (Separate Child Health Program)

Uninsured children under the age of one with family income more than 185% of the Federal poverty level (FPL), but less than 300% of the FPL, and uninsured children age one through age 18 with family income between 151% and 300% of the FPL are covered under a Separate Child Health Program entitled the MO HealthNet For Kids Program. The MO HealthNet for Kids Program occurs under a Title XXI CHIP State Plan. No new eligible is excluded because of pre-existing illness or condition. Children in families with income above 150% of FPL are not eligible if they have access to affordable insurance.

Children eligible for the MO HealthNet for Kids Program receive a benefit package of essential medically necessary health services, excluding NEMT. This benefit is so unheard of in any health insurance plan that its inclusion services as a significant incentive for dropping of private coverage. Prescription drugs are subject to the national drug rebate program requirements. The MO HealthNet Fee-For-Service Program is utilized in regions where Managed Care is not available. When Managed Care begins in these areas, Title XXI eligibles will be enrolled in Managed Care.

Program of All-Inclusive Care for the Elderly (PACE)

This program is a comprehensive service delivery system for the frail elderly. To be eligible to enroll in the PACE Program individuals must be 55 years of age or older, reside in the service area of the PACE organization, be determined by the Missouri Department of Health and Senior Services to need the level of care required for nursing facility services, and be recommended by the PACE staff for PACE Program services as the best option for their care. Individuals may be entitled to Medicare Part A, enrolled under Medicare Part B or be eligible for MO HealthNet to enroll in the PACE Program.

The PACE Organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week to PACE participants.

Alexian Brothers Community Services (ABCS), currently the only PACE organization in the state, received permanent provider status and became fully operational effective November 1, 2001. ABCS is operational in all zip codes in St. Louis County and St. Louis City.

B. Quality Improvement Strategy Objectives

Quality Improvement Strategy (QIS) Overview

Missouri's Quality Improvement Strategy (QIS) is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement process to coordinate, assess, and continually improve the delivery of quality care and services to participants in Managed Care, waivers, and Medicaid funded programs. The QIS provides a framework to communicate the State's vision, objectives, and monitoring strategies addressing issues of health care cost, quality, and timely access. The QIS is collaboration through partnerships with enrollees, stakeholders, other state agencies, managed care organizations (MCOs), and community groups.

The QIS supports the mission of the Department of Social Services (DSS) to maintain or improve the quality of life for the people in the State of Missouri by providing the best possible services to the public, with respect, responsiveness, and accountability which will enable individuals and families to better fulfill their potential. The Department of Social Services (DSS), MO HealthNet Division (MHD) seeks to assure access and availability of quality health care services for Managed Care members through a Managed Care delivery system, standards setting and enforcement, and education of providers and members.

This QI strategy supports the following MHD objectives:

- Assessment of the quality and appropriateness of care and services furnished to members, including those with special health care needs, centered on evidenced based practice;
- Use of care management with emphasis on the individual member to ensure that members have a medical home which focuses attention on the wellness of the member and includes personal responsibility and investment on the part of the member;
- Use of data regarding the race, ethnicity, and primary language spoken of each member to improve care delivery;
- Use of national performance measures and levels when identified and developed by CMS in consultation with states and other relevant stakeholders;
- An effective information system that supports initial and ongoing operation and review of the quality strategy;
- A process for public input that provides for the integration of various perspectives and priorities and will facilitate improvements in member health status;
- Appropriate use of sanctions, including intermediate sanctions, to assure appropriate delivery of care to members; and

- Compliance with regulatory and contractual requirements.

The goal is to ensure that:
- Quality health care services are provided to Managed Care members;
- MCOs are in compliance with Federal, State, and contract requirements; and
- A collaborative process is maintained to collegially work with the MCOs to improve care.

The Missouri Department of Social Services, MO HealthNet Division has identified eight (8) guiding principles for the MO HealthNet Program as follows:
- All participants must have a health care home,
- Attention to wellness of the individual (i.e. education),
- Chronic care management,
- Case management – (resources focused towards people receiving the services they need, not necessarily because the service is available),
- Appropriate setting at the right cost,
- Emphasis on the individual person,
- Evidenced based guidelines for improved quality care and use of resources, and
- Encourage responsibility and investment on the part of the participants to ensure wellness.

Quality Improvement Strategy (QIS) Development

The QIS is evaluated on an annual basis by MHD and MCO quality staff for effectiveness. This process includes obtaining input from stakeholders (i.e. advocates, consumers, and providers), the Quality Assessment & Improvement (QA&I) Advisory Group, Consumer Advisory Committee (CAC), and other state agencies (the Departments of Mental Health; Social Services; Insurance, Financial Institutions, and Professional Registration; Elementary and Secondary Education; and Health and Senior Services). In the instance there is significant change in outcome or indicator status that is not self-limiting and impacts on more than one area of the population's health status, modifications will be made to the QIS reporting process. Results of the annual External Quality Review (EQR) and the MCOs annual evaluation of their QA&I programs are considered during the QIS annual evaluation. Modifications to the QIS may include changes to the monthly, quarterly and annual MCO reports, on-site review topics, Managed Care performance measures, and Managed Care performance improvement projects. The QIS may be reviewed and revised more frequently if program changes occur that impact quality activities or threaten the potential effectiveness of the strategy.

Member Input

The State realizes that the keys to a successful Managed Care Program include the provision of quality services, the satisfaction of enrollees, and the involvement of stakeholders. In awareness of the importance of stakeholder involvement, the State formed the Consumer Advisory Committee (CAC), which includes advocacy groups, MCOs, and Managed Care members, to advise the Director of the MO HealthNet Division on issues relating to enrollee participation in the Managed Care Program. Consumer input into services, processes, and programs is obtained through quarterly

meetings of the Consumer Advisory Committee (CAC) and from annual Consumer Assessment of Healthcare Providers and Systems (CAHPS). The committee consists of a minimum of fifteen enrollees and advocates. As the State develops and refines educational materials, the CAC is instrumental in making recommendations to enhance consumer education as well as any changes needed to improve either the care provided or the way care is delivered.

Consumers and non-consumers are encouraged to bring a variety of Managed Care issues to the CAC for discussion and action. Every effort is made to fill a vacancy as it occurs. When a vacancy does occur, the State solicits recommendations for membership through quarterly All Plan meetings, Quality Assessment and Improvement (QA&I) Advisory Group meetings, and CAC meetings. Family Support Division (FSD) eligibility specialists, Department of Mental Health (DMH) representatives, and other interested state and local agencies are also contacted and encouraged to submit names for consideration. In 2008, a flyer was developed and distributed by the MCOs to encourage member participation. The flyer was also posted on the MO HealthNet Division's website.

Public Input

In an effort to involve various stakeholders, especially those persons with special health care needs, the State has used the following forums:

- Quarterly meetings with provider groups, such as physicians, dentists, hospice providers, the Drug Utilization Review Board, the Managed Care All Plan Administrators, the CAC, and the QA&I Advisory Group and related subgroups;
- Frequent interactions with the State's Consumer Advocacy Projects (ombudsmen services) regarding ways to help individuals access care easier and ways to coordinate care with other state agencies;
- Publication of the RFP on the State web site;
- Publication of provider bulletins on the State website regarding MO HealthNet Managed Care issues; and
- Collaboration and regular meetings with Department of Health and Senior Services (DHSS), DMH, and the Department of Elementary and Secondary Education (DESE), as well as with sister agencies within the Department of Social Services.

After comments are gathered from these stakeholders, policy is developed or changed to incorporate suggestions that impact the MO HealthNet Managed Care Program. For instance, the QA&I Advisory Group recommended and the State implemented the following protocols: guidance on intensity of care decisions regarding the hospital care of premature infants and guidance on approving speech therapies that are duplicated by those therapies specified in an Individualized Education Plan (IEP). In 2004 the QA&I Advisory Group also developed a Pre-Natal Risk Screening Tool to be used by the MCOs to increase and document risk screening for pregnant women. Additionally in 2004, the State and DMH worked with the MCOs and the Consumer Advocacy Project (CAC) to develop protocols for how to coordinate behavioral health care provided by the MCOs and DMH. In 2006, the State and DMH developed a protocol to facilitate referral of pregnant women in Managed Care in need of substance abuse treatment to

Comprehensive Substance Abuse Treatment and Rehabilitation Program (CSTAR). The protocol guides collaboration between the primary care provider (PCP), CSTAR provider, MCO case manager and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services.

In addition to these on-going activities, a large amount of information was gathered by the State during the testimony and hearings held on House Bill (HB) 335. HB 335 passed the Missouri General Assembly in 1997 and addressed managed care issues such as patient's rights, grievances and appeals, the definition of an emergency, network adequacy, and enrollee notice in utilization review decisions. Literally hundreds of providers, advocates, and citizens (including those with special health care needs) testified on this legislation. The testimony helped shape this law, which was incorporated into the State's contracts with MCOs.

Quality Improvement Strategy (QIS) Approval

Once input has been received and incorporated into the QIS, the final QIS document is presented to and approved by the QA&I Advisory and All Plan groups. Following approval by the QA&I Advisory Group, the quality strategy is sent to CMS for approval

Quality Improvement Strategy (QIS) Implementation

The Managed Care Quality Assessment and Improvement (QA&I) Advisory Group was created with the inception of Managed Care. The purpose of the QA&I Advisory Group is to impact service utilization through collaborative monitoring and continuous quality improvement activities. The QA&I Advisory Group and task forces assist in maintaining an open forum for collaboration and communication among MCOs, other stakeholders (i.e. advocates, consumers, and providers), and state agencies (the Departments of Mental Health; Social Services; Insurance, Financial Institutions, and Professional Registration; Elementary and Secondary Education; and Health and Senior Services). The QA&I Advisory Group meets quarterly.

The QA&I Advisory Group designate task forces as necessary to work on specific performance improvement initiatives. The initiative activities may include, but are not be limited to, identification of indicators, evaluation of outcomes, and the development of recommendations for intervention strategies. The task forces exist for a specific designated period and are terminated when the desired outcome is reached. Reports of task force meetings, actions and outcomes are regularly presented to the QA&I Advisory Group. Task force members include MCO quality staff, other stakeholders, and state agency staff. The QA&I Advisory Group task forces that have been convened include, but are not limited to: Maternal Child Health, Dental, Behavioral Health, External Quality Review Organization (EQRO), and National Committee for Quality Assurance (NCQA). The task force leader/facilitator works directly with and is accountable to the chair of the QA&I Advisory Group. The chair of the QA&I Advisory Group works directly with state agency staff.

The All Plan members (MCO administrators) evaluate initiatives recommended by the QA&I Advisory Group. The All Plan members guide operations and promote and protect the health and safety of the Managed Care enrollees. They create and foster an

environment that provides quality care consistent with Managed Care enrollee needs and the goals of the Managed Care Program.

Quality Strategy Objectives and Results

The Managed Care Program enables Missouri to use the managed care system to provide Medicaid services to Section 1931 children and related poverty level populations; Section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children in the Eastern, Central, and Western regions of the state.

The objectives of Managed Care Program continue to be cost containment while enhancing the quality and continuity of care and ensuring access to appropriate care for Managed Care members.

Services are monitored for quality, enrollee satisfaction, and contract compliance. Quality is monitored through various on-going methods including, but not limited to, MCO Healthcare Effectiveness and Data Information Set (HEDIS) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and annual external quality reviews.

Other measurements of enrollee satisfaction include the percentage of Managed Care enrollees who selected their own MCO; the low percentage of Managed Care enrollees who request transfers; and the low percentage of Managed Care enrollees randomly assigned.

In addition to quality assessment and enrollee satisfaction monitoring, MCO compliance with contractual requirements is a primary method of measuring attainment of managed care goals. Contractual compliance monitoring begins with the issuance of the Request for Proposal (RFP) and continues with the review of proposals submitted, assessment of MCO provider networks, and readiness reviews of MCOs' operations.
Missouri's Managed Care Program is focused on providing quality care to recipients enrolled in the program through increased access and appropriate and timely utilization of health care services. Goals and objectives provide a reminder of program direction and scope.

The MO HealthNet Division, in collaboration with the Departments of Mental Health and Health and Senior Services (DHSS), identifies measures that must be reported by the MCOs to the MO HealthNet Division and DHSS. The measures that are monitored are reported to and approved by the members of the QA&I Advisory Group and the All Plan Meeting. The MO HealthNet Division, in collaboration with the MCOs, and the Departments of Mental Health and Health and Senior Services identifies benchmarks and targets for the measures.

The goals and objectives that play a significant role in the development of the quality strategy include the following:

Goals and Objectives

Goal 1: To increase/decrease the use of MO HealthNet Services by members.

Objectives:

Measures collected for Calendar Year 2006-2008:

- (H) Increase Well Child Visits in the First 15 Months of Life by 2% annually except zero visits which should decrease *;
- (H) Increase the rate of Well-Child Visits in Children in the 3rd,4th, 5th, and 6th Years of Life by 2% annually *;
- (H) Increase Adolescent Well-Care Visits by 2% annually *;
- Increase Members Behavioral Health Utilization annually by 2%;
- Increase Behavioral Health Residential Days annually by 2%;
- Increase Substance Abuse Days annually by 2%;
- Increase Substance Abuse Discharges annually by 2%;
- Increase Partial Hospital Days annually by 2%;
- Increase Partial Hospital Discharges annually by 2%;
- Increase Behavioral Health Outpatient Visits annually by 2%;
- Increase Alternative Services annually by 2%;
- Decrease Behavioral Health Inpatient Readmission Rates annually by 2%;
- Decrease Behavioral Health Average Length of Stay annually by 2%;
- Decrease the number of preventable hospitalizations for children by 2% annually;
- Decrease the number of preventable asthma hospitalizations for children by 2 % annually;
- Decrease the number of Emergency Room visits for children by 2% annually;
- Decrease the number of Emergency Room asthma visits for children by 2% annually;

Measures for which initial data is being collected:

- Increase the overall behavioral health penetration by 2 % annually*;
- Increase behavioral health outpatient visits by 2% annually;
- Increase by 2% annually members having access to behavioral health practitioners and providers within the geographic distances specified in the Network Adequacy Standards until > 90 percent have access to services;
- Decrease behavioral health Emergency Room visits by 2% until meet NCQA Quality Compass between the 25th-75th percentile;
- Decrease behavioral health inpatient days by 2% annually;
- Decrease behavioral health substance abuse days by 2% annually;
- Decrease inpatient behavioral health discharges by 2% annually;
- Decrease substance abuse discharges by 2% annually.

* Healthcare Effectiveness Data and Information Set (HEDIS) Measures

Goal 2: To improve the effectiveness of care provided to the MO HealthNet members.
Objectives:
Measures collected for Calendar Year 2006-2008:

- (H) Increase the Use of Appropriate Medications for Children with Asthma by 2 % annually*;
- Increase the EPSDT screening rate, annually, by 2%;
- (H) Increase by 3%, annually, the percentage of children two years of age who had 4 diphtheria, tetanus and acellular pertussis(DTaP), 3 polio (IPV), one measles, mumps and rubella (MMR), 3 H influenza type B (HIB), 3 hepatitis B, 1 chicken pox (VZV) and 4 pneumococcal conjugate vaccines by their second birthday *;
- (H) Increase by 5% the percentage of enrolled members 12-21years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year *;
- Increase by 2% annually 7 Day Ambulatory Follow-Up;
- Increase by 2% annually 30 Day Ambulatory Follow-Up;
- (H) Increase by 2% annually Cervical Cancer Screenings*;
- (H) Increase by 2% annually Chlamydia Screening in Women*;

Measure for which initial data is being collected:

- (H) Increase by 2% annually the Follow-up After Hospitalization For Mental Health Disorders until benchmark goal (NCQA Quality Compass 50th percentile) is reached*.

Goal 3: To improve the access/availability of care provided to the MO HealthNet members.
Objectives:
Measures collected for Calendar Year 2006-2008:

- Increase the number of children enrolled in CHIP by 2% annually;
- Increase the number of children in the MO HealthNet Program, excluding CHIP, by 2% annually;
- Increase the number of primary care providers enrolled in the MO HealthNet Program by 2% annually;
- (H) Increase by 3%, annually, the number of children who receive annual dental visits *;
- (H) Increase by 2% annually the number of members receiving Prenatal and Postpartum Care*;
- (H) Increase by 2% annually the number of members using Ambulatory Care*;
- (H) Mental Health Utilization Increase by 2% annually Intermediate and Ambulatory and decrease by 2% inpatient care–Percentage of Members Receiving Inpatient, Intermediate Care and Ambulatory Services*;
- (H) Increase by 2% annually the Identification of Alcohol and Other Drug Services;

* Healthcare Effectiveness Data and Information Set (HEDIS) Measures

Measures for which initial data is being collected:

- Increase the number of participants who self select a Primary Care Provider by 5% annually;
- Increase by 2% annually the number of behavioral health providers (Psychiatrists, Psychologists, and all other behavioral health providers)/1000 members statewide and regionally;
- Increase by 2% annually the full time equivalent (FTE) of behavioral health providers (Psychiatrists, Psychologists, and all other behavioral health providers)/1000 statewide and regionally;
- Increase by 2% annually the number psychiatrists with open panels for children $\leq$ 6 years old, children 7-12 years old, adolescents (13-17 years old), and adults ($\geq$ 18 years old) to 70% open panels;
- Increase by 2% annually psychiatrist appointment availability for children $\leq$ 6 years old, children 7-12 years old, adolescents (13-17 years old), and adults ($\geq$ 18 years old) until 85% or more of psychiatric practices treating children will have routine appointments available within 10 business days (NCQA standard);
- Increase by 2% annually psychiatrist overall appointment availability until 85% or more of psychiatrist practices will have appointments available to meet NCQA QI 5 Element B; a) Emergent (non-life threatening)-within 6 hours; b) Urgent-within 48 hours; c)Routine-within 10 business days.

Goal 4: Satisfaction with the Experience of Care
Objectives:
Measure collected for Calendar Year 2006-2008:

- (H) CAHPS Health Plan Survey, Child Version*

Measure for which initial data is being collected:

- (H) CAHPS Health Plan Survey, Adult Version*

Monitoring Results

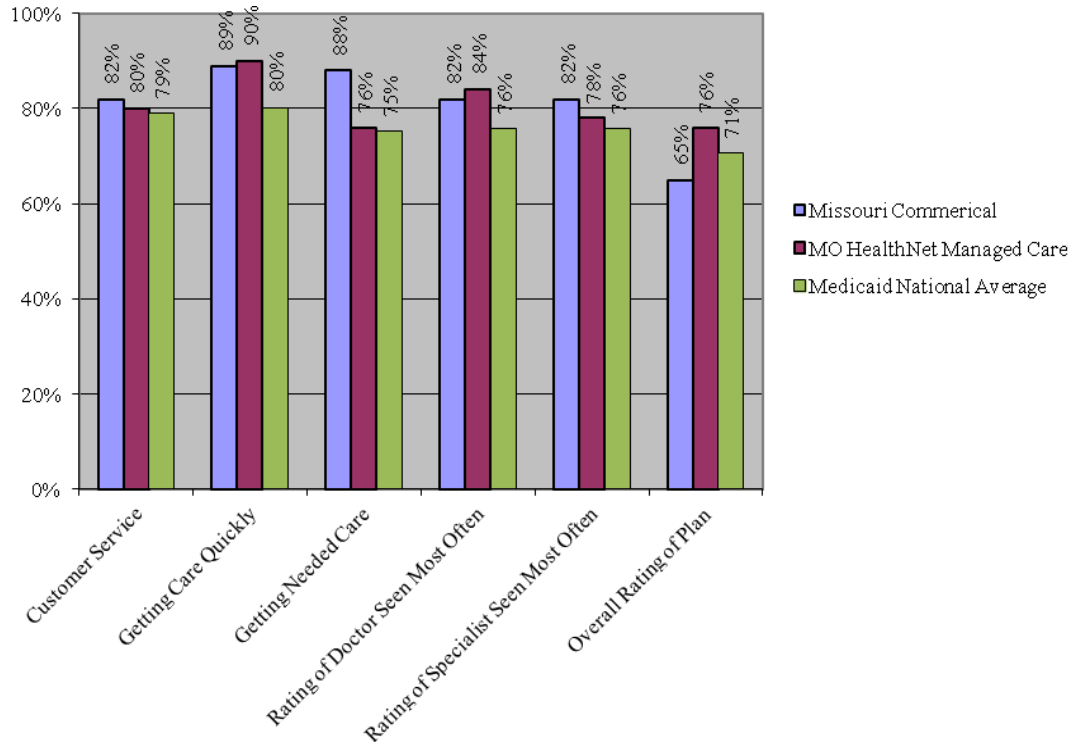
Section 1915(b) of the Social Security Act and 42 CFR 431.55 require the State to document and maintain data regarding the effectiveness of the waiver on accessibility and quality of services. This section identifies the data the MHD reviews to evaluate the MCOs contracted with the MHD.

Consumer Assessment of Health Plans Survey (CAHPS): An analysis of the 2009 CAHPS for CY 2008 (Figure 1) data indicates that all the MCOs received a mostly average rating. Three of the six MCOs, HealthCare USA (HCUSA) in the Eastern and Central Regions, Children's Mercy Family Health Partners in the Western Region, and Molina Healthcare of Missouri in the Central and Western Regions, received a high rating in five categories of the CAHPS. HCUSA in the Central Region received a high rating in three categories: Getting Needed Care, Getting Care Quickly, and Overall Rating of Plan. Children's Mercy Family Health Partners in the Western Region and HCUSA in the Eastern Region received a high rating for Overall Rating of Plan. Molina Healthcare of Missouri in the Central Region received a high rating for Rating of Doctor.

* Healthcare Effectiveness Data and Information Set (HEDIS) Measures

Molina Healthcare of Missouri in the Western Region received a high rating for How Well Doctors Communicate.
A true comparison cannot be performed because the Missouri commercial product utilizes the Adult CAHPs and Medicaid utilizes the Child CAHPs, But in reviewing the statewide averages regarding member satisfaction between Managed Care and Commercial products, the Managed Care statewide averages are very near or better than the Commercial statewide averages indicating consumers enrolled in the Managed Care Program may be as satisfied as consumers enrolled in Commercial products. This data is compiled and posted on the DHSS website at http://www.dhss.mo.gov/ManagedCare/.

Member Satisfaction of Missouri Commercial, Managed Care Health Plan Performance, and Medicaid MCO National Averages (Figure1)



Member Grievance System: The MCOs are required by the MHD Managed Care contract to have a system in place for members which includes a grievance process (an expression of dissatisfaction), an appeal process (a request for review of a denial or limited authorization of a requested service), and access to MHD's State Fair Hearing Process.

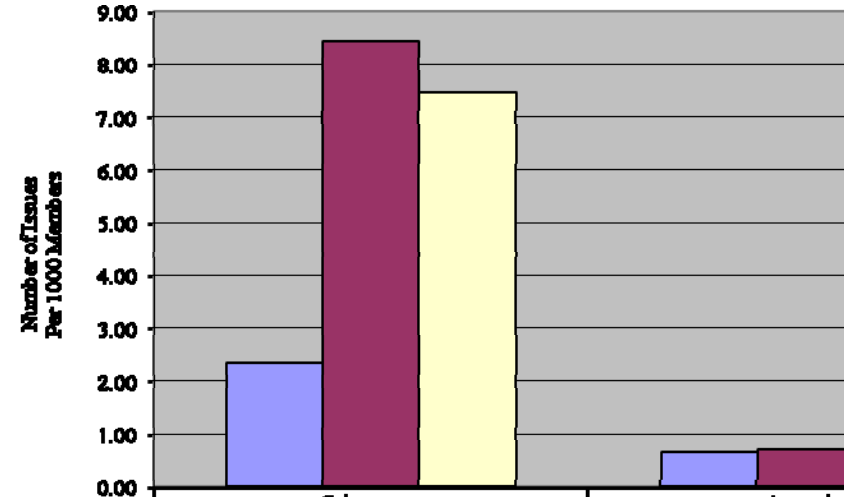
Member Grievances and Appeal: The most frequent grievances were waiting times (transportation), member receiving bills/provider requests payment before rendering services and condition of office/transportation. The proportion of transportation grievances was lower in the Central Region than in the Eastern and Western Regions. The Western Region had the highest proportion of transportation grievances.

In the Central Region, members receiving bills/provider requests payment before rendering services had the highest proportion of grievances followed waiting times (transportation) and condition of office/transportation.
In the Eastern Region, waiting times (transportation) had the highest proportion of grievances followed by members receiving bills/provider requests payment before rendering services and condition of office/transportation.

In the Western Region, waiting times (transportation) had the highest proportion of grievances followed by members receiving bills/provider requests payment before rendering services and provider staff behavior.

The most frequent appeal in all regions was service denial followed by payment denial and other (Figure 2).

SFY 2008 Member Grievance and Appeal Summary Total Number of Member Grievances and Appeals Reported in SFY 2008* Based on the Average Regional Monthly Enrollment (Figure 2).**



	Grievances	Appeals
Central Region	2.37	0.66
Eastern Region	8.44	0.72
Western Region	7.47	2.38

*Numerator
**Denominator

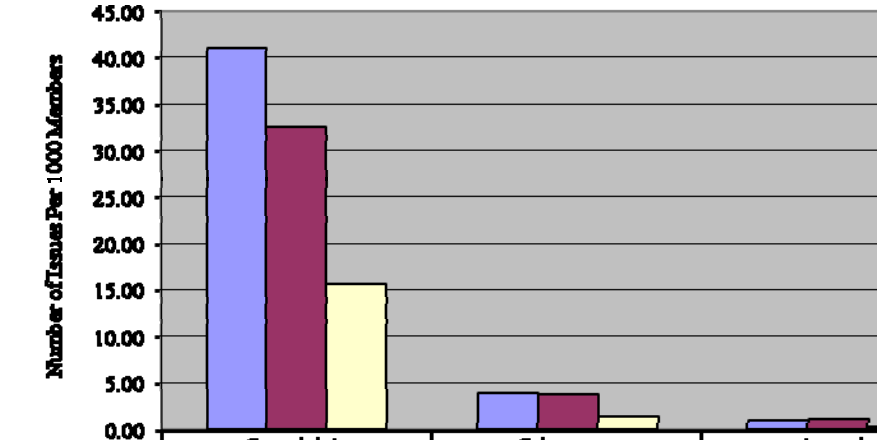
Source: Missouri Department of Social Services, Managed Care, aggregate quarterly grievances data.

Provider Complaint and Appeals: The MCOs are required by the MHD Managed Care contract to establish a provider complaint and appeal process that provides for the timely and effective resolution of any disputes between the MCO and providers. This system is specific to providers and does not replace the member grievance system which allows a provider to submit a grievance or an appeal on behalf of a member. When a provider submits a grievance or appeal on behalf of a member, the requirements of member grievance system shall apply.

Provider Complaints, Grievances and Appeals: The most frequent statewide complaints, grievances or appeals were for claim denial followed by service denial. All

other provider complaint, grievance, and appeal categories yielded results less than one member per 1000 for SFY2008. The MCOs resolved the majority of the complaints with the provider before they became a grievance or appeal (Figure 3).

SFY 2008 Provider Complaint, Grievance and Appeal Summary. Total Number of Complaints, Grievances and Appeals Reported in SFY 2008*. Based on the Average Regional Monthly Enrollment (Figure 3).**



	Complaints	Grievances	Appeals
Central Region	41.08	3.96	1.04
Eastern Region	32.60	3.77	1.20
Western Region	15.59	1.39	0.38

*Numerator
**Denominator

Source: Missouri Department of Social Services, Managed Care, aggregate quarterly grievances data.

Maternal and Child Health Indicators: In the CY2006 through September 2007 comparison, the Managed Care enrollee group showed significant gains on three of the nine maternal/infant indicators. For the CY2006 through September 2007 comparison, the Managed Care enrollee group continued to demonstrate significantly greater rates of change over time than both the MO HealthNet Fee-for-Service participant and Non-Medicaid groups on:

- Prenatal Care During the First Trimester
- Birth Spacing Less than 18 Months
- Births to Mothers Younger than 18 Years

All groups showed significant changes in the C-Section rate and the rate of pregnant women enrolled in the Women, Infants, and Children (WIC) Program, in the negative direction. Given the national and statewide trends in C-Section rates, it will be challenging for MCOs to directly impact patient choice and provider practice. However, the continued collaboration and coordination with local public health agencies (LPHAs) holds promise for improving participation in the WIC Program. An examination of the barriers, needs, and perceptions of patients and providers may provide information for education and outreach efforts.

The four child health indicators were preventable hospitalizations, emergency room visits, asthma emergency room visits, and asthma hospitalizations, all for persons under age 18. There were no dramatic changes in any of the indicators from 2004 to 2008. However the rate of total emergency room visits did increase by 16 percent among Managed Care children under age 18 from 2004 to 2008 while comparable Fee-For-Service rate increased by 2 percent. Asthma rates did not change much, but the rates were generally higher in the managed care regions than in the fee-for-service regions. Rates for CHIP clients generally were between the Managed Care and the non-MO HealthNet populations for all four indicators. The rates for the CHIP populations increased for all four indicators from 2004 to 2008.

- Preventable Hospitalizations Under Age 18
- Emergency Room Visits Under Age 18
- Asthma Emergency Room Visits, 4 – 17 years of age
- Asthma Admissions under age 18 years

Geographic Mapping: The State annually evaluates the access submitted by the MCOs. The State calculates the enrollee access rate for each type of provider in each county the MCO serves to determine if the average enrollee access rate for each county and the average enrollee access rate for all counties is greater than or equal to ninety percent (90%). The entire Managed Care population is used in the calculation for each MCO. The 2009 Network Analysis completed by the State determined that all MCOs met the 90% overall network score standard (Figure 4).

Network Analysis – Rate of Compliance 2009 (Figure 4)

MCO	PCPs	Specialists	Facilities	Ancillary	Overall network score
Blue Advantage Plus	100%	99%	91%	96%	**97%**
CMFHP	100%	100%	100%	99%	**100%**
Harmony	100%	97%	99%	100%	**99%**
Healthcare USA - Central	100%	100%	99%	100%	**100%**
Healthcare USA - East	100%	99%	100%	100%	**100%**
Healthcare USA - West	100%	100%	98%	100%	**100%**
Missouri Care	100%	99%	100%	100%	**100%**
Molina - Central	100%	100%	94%	100%	**98%**
Molina - East	100%	100%	100%	100%	**100%**
Molina - West	99%	100%	92%	100%	**98%**

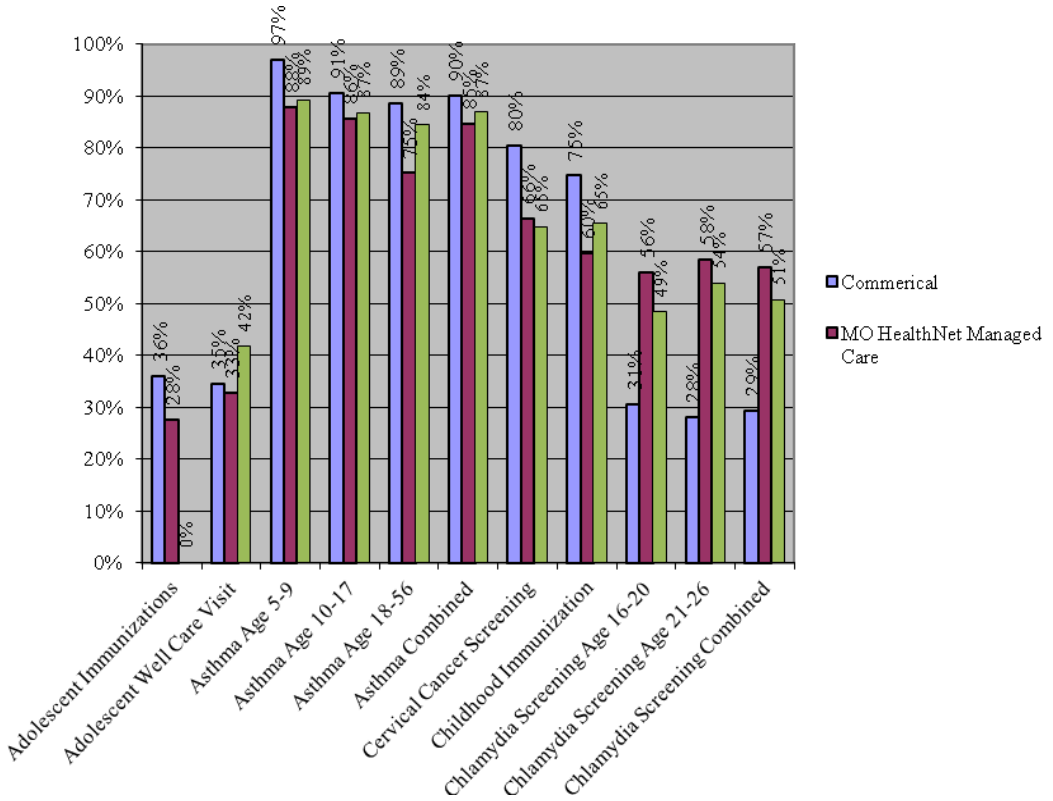
Per 20 CSR 400-7.095(3)(A)1, each MCO's enrollee access for each type of provider in each county in the MCO's approved service area is calculated by the State to determine if the average enrollee access rate for each county and the average enrollee access rate for all counties is greater than or equal to ninety percent (90%).

Network Adequacy Assurance by MCO: The State determines the average distance to PCPs, the PCP/enrollee ratios, and the dentist/enrollee ratios. Each MCO exceeds the PCP distance standard per the Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP) regulation (20 CSR 400-7.095(3)(A)1.B).

HEDIS Performance Measures: Managed Care performance measures are required to be reported in accordance with HEDIS specifications to the Department of Health and Senior Services (DHSS) and MHD per State regulation 19 CSR 10-5.010 and the Managed Care contract. Both DHSS and MHD analyze the performance measures to compare MCOs' performance to the statewide average. The percent on the "Statewide Averages" line indicates the average percent of all MCOs for each indicator. An Average rating for a specific MCO means the MCO scored close to the Statewide Average for that indicator. A High or Low rating means the MCO scored much higher or much lower than the Statewide Average.

Figure 5 is a comparison of performance measures of commercial and Managed Care. An analysis of statewide averages of performance measures reported to DHSS for the 16 Commercial and 9 Managed Care products for Calendar Year 2008 indicate the Commercial product is outperforming the Managed Care product in all measures with the exception of Chlamydia Screenings. The Managed Care product is performing within 15 percentage points of the Commercial product. The Managed Care product was not included in the analysis as Managed Care serves a different age population. Therefore, the Commercial performance measures that were reported are different than the Managed Care products.

Comparison of Performance Measures of Missouri Commercial, Managed Care Health Plan Performance, and Medicaid MCO National Averages (Figure 5).

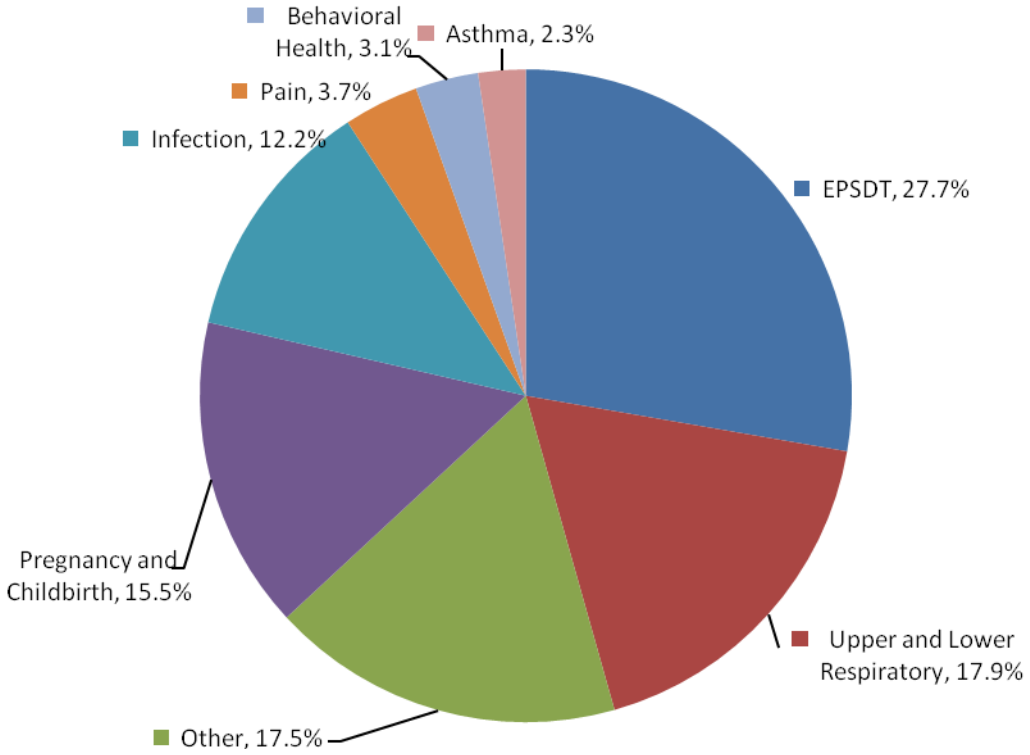


Sources: Missouri Commercial and Managed Care: Missouri Department of Health and Senior Services 2008 HEDIS Measures
Medicaid National Average: NCQA 2008 National Quality Compass (Adolescent Immunizations data is not available)

Utilization Review

Outpatient and Medical Encounters: The top thirty International Classification of Diseases, Ninth Revision (ICD-9) codes in the first diagnosis field on the outpatient and medical encounter claim file layout were grouped into seven categories that represented 39.7% of all outpatient and medical encounters (Figure 6). Of these top thirty diagnosis codes the majority of outpatient encounters were for preventive care (27.7% for EPSDT) followed by upper and lower respiratory conditions (17.9%), 'other'(17.5%), pregnancy and childbirth (15.5%), infections (12.2%), pain (3.7%), behavioral health (3.1%) and asthma (2.3%). The category 'other' was comprised of ICD-9 codes for allergic rhinitis, dermatitis, fever, chest pain, routine medical and gynecological exams and housing/economic circumstances.

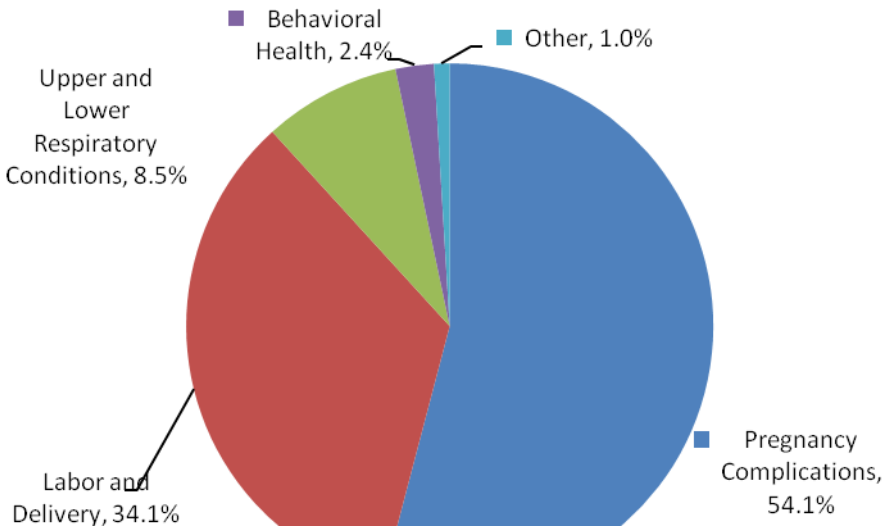
Most Frequent Reason for Visits SFY 2008
(Figure 6)



Source: Missouri Department of Social Services, MO HealthNet Division

Inpatient Encounters: The top thirty International Classification of Diseases, Ninth Revision (ICD-9) codes in the first diagnosis field on the inpatient encounter claim file layout were grouped into five categories that represented 58.2% of all inpatient encounters (Figure 7). The primary reason for an inpatient encounter was related to "pregnancy complications" (54.1%) and is comprised of ICD-9 codes such as preterm labor, pregnancy-induced hypertension, and gestational diabetes. It is followed by normal labor and delivery (34.1%) upper and lower respiratory conditions (8.5%), behavioral health (2.4%) and 'other' (1.0%).

Top Reasons for Hospitalization, SFY 2008
(Figure 7)



Source: Missouri Department of Social Services, MO HealthNet Division

Dental Service Utilization: MCOs are required to provide dental services. The Managed Care Policy Statement for dental services states that MCOs must conduct EPSDT screens on enrollees under the age of 21 to identify health and developmental problems. It is recommended that preventive dental services and oral treatment for children begin at age 6 to 12 months and be repeated every six months or as medically indicated. Although an oral screening may be part of a physical examination, an oral screening does not substitute for an examination through direct referral to a dentist.

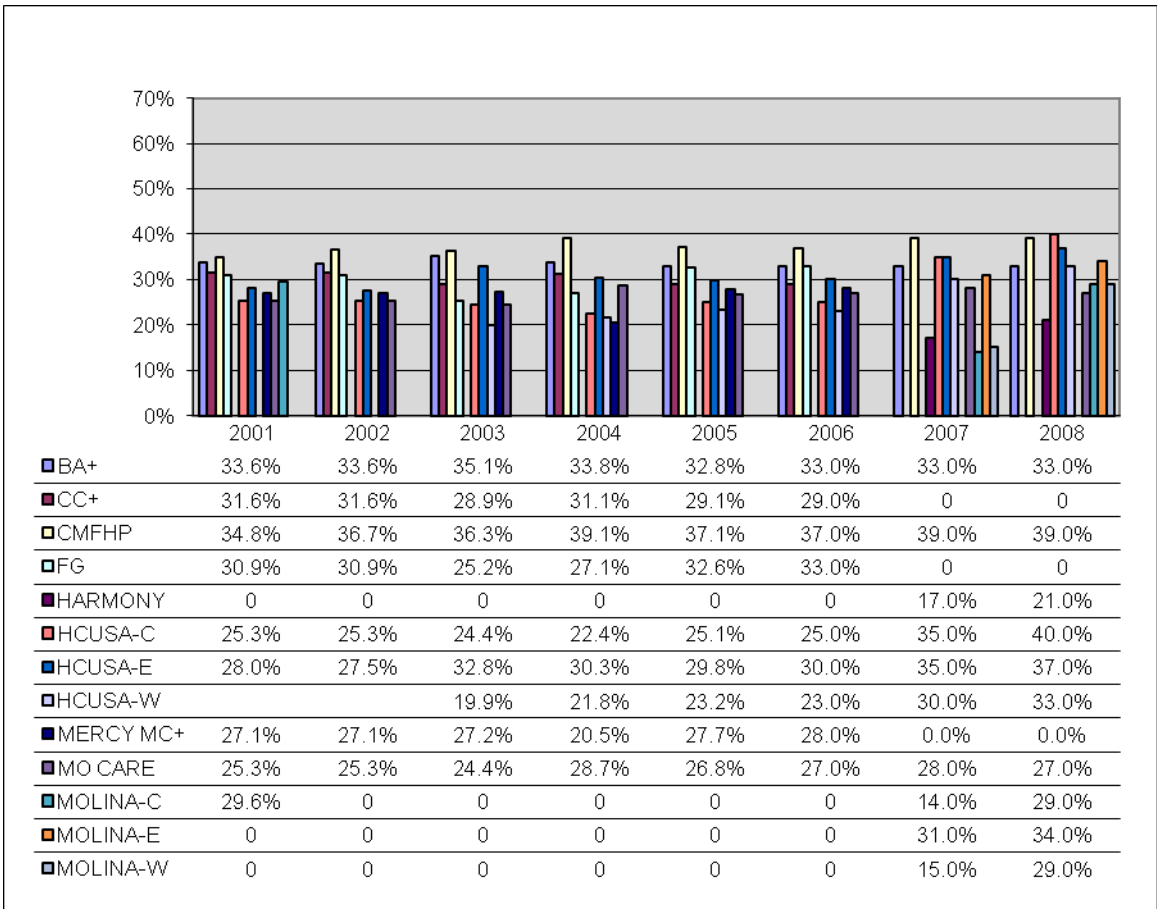
In the Managed Care Program, the MCOs currently delegate dental services to Dental Benefit Management Organizations; however, the MCOs are responsible for ensuring that State requirements and health care needs for Managed Care enrollees are met.

Several sources of data were reviewed to examine the access and use of dental services among Managed Care enrollees. First, a State mandated reporting indicator (Health Employer Data Information Set; HEDIS) for annual dental visits was examined (HEDIS 2009; for data year 2008). Second, the adequacy of MCO dental provider networks was examined.

Annual Dental Visit Rates: The MCOs must report annual dental examination rates to the DHSS on an annual basis. Rates are based on HEDIS calculations of the proportion of Managed Care enrollees who were four to 21 years of age, continuously enrolled during the measurement year, and who had at least one dental visit during the measurement year.

In CY2008, the MCO HEDIS rates for annual dental visits ranged from 21.0% to 40.0%, with an average of 32.2%. DHSS categorized these rates as "Low/Needs Improvement, Average, or High/Good" based on how each MCO compared to the average of all the MCOs. Using these ratings, five MCOs (Children's Mercy Family Health Partners, Healthcare USA – Eastern Region, HealthCare USA – Central Region, HealthCare USA – Western Region, and Molina Healthcare of Missouri – Eastern Region) received a "high" rating, and one MCO (Blue-Advantage Plus of Kansas City) received an "average" rating, and four MCOs (Harmony Health Plan of Missouri, Missouri Care Health Plan, and Molina Healthcare of Missouri – Western Region) received a "low" rating. Figure 8 illustrates the annual dental examination rates for each of the MCOs from CY2001 to CY2008.

HEDIS Quality Indicator Rates: Annual Dental Visits, CY2001-CY2008
(Figure 8)



	2001	2002	2003	2004	2005	2006	2007	2008
BA+	33.6%	33.6%	35.1%	33.8%	32.8%	33.0%	33.0%	33.0%
CC+	31.6%	31.6%	28.9%	31.1%	29.1%	29.0%	0	0
CMFHP	34.8%	36.7%	36.3%	39.1%	37.1%	37.0%	39.0%	39.0%
FG	30.9%	30.9%	25.2%	27.1%	32.6%	33.0%	0	0
HARMONY	0	0	0	0	0	0	17.0%	21.0%
HCUSA-C	25.3%	25.3%	24.4%	22.4%	25.1%	25.0%	35.0%	40.0%
HCUSA-E	28.0%	27.5%	32.8%	30.3%	29.8%	30.0%	35.0%	37.0%
HCUSA-W			19.9%	21.8%	23.2%	23.0%	30.0%	33.0%
MERCY MC+	27.1%	27.1%	27.2%	20.5%	27.7%	28.0%	0.0%	0.0%
MO CARE	25.3%	25.3%	24.4%	28.7%	26.8%	27.0%	28.0%	27.0%
MOLINA-C	29.6%	0	0	0	0	0	14.0%	29.0%
MOLINA-E	0	0	0	0	0	0	31.0%	34.0%
MOLINA-W	0	0	0	0	0	0	15.0%	29.0%

Source: Missouri Department of Health, Center for Health Information Management & Evaluation, 2001, 2002, 2003, 2004, 2005, 2006, 2007, and 2008. HEDIS Quality Indicator Rates. Retrieved from http://www.dhss.state.mo.us/ManagedCare/.

Dental Provider Network: The availability of actively practicing dentists in Missouri, especially those accessible to low-income persons, has been cited as a reason for low dental service rates. The Centers for Disease Control and Prevention (CDC) reported that in 2008, Missouri had 2,369 dentists[1] of which 26% were enrolled in MO HealthNet. A 2009 Department of Insurance, Financial Institutions, and Professional Registration (DIFP) network adequacy analysis found that all counties served by the MCOs had a 90-100% adequacy score, meeting or exceeding a 90% guideline.

[1]Oral Health Resources, Synopses by State. Centers for Disease Control and Prevention (CDC). www.cdc.gov Retrieved 11/06/2008.

Dental Encounter Claims: MHD encounter claims for SFY 2008 were summarized for dental utilization patterns by age for MO HealthNet children (Managed Care enrollees and MO HealthNet Fee-For-Service participants). A total of 151,653 (220 children per 1,000 participants/enrollees) Managed Care enrollees and Fee-For-Service participants ages 18 years and younger had claims for dental office visits during SFY2008.

There was not a large difference of Managed Care enrollees with an office visit compared to MO HealthNet Fee-for-Service participants. In SFY2008 the MO HealthNet Fee-for-Service group had a rate of 216 children per 1,000 while the Managed Care group had a rate of 223 children per 1,000 enrollees.

Three additional encounter claim summaries were examined and compared for differences in MO HealthNet Fee-For-Service participant and the Managed Care enrollee groups for ages 18 and younger. The three measures were gum disease, dentures, and extractions.

Data for SFY2008 showed that 987 MO HealthNet children had claims for gum disease. Of these 380 were Managed Care enrollees and 607 were MO HealthNet Fee-For-Service participants. The Managed Care group showed a lower gum disease rate of 1.03 children per 1,000 enrollees than the Fee-for-Service group with a rate of 1.9 children per 1,000 participants.

A total of 159 MO HealthNet children had claims for dentures in SFY2008. Of these, 96 were Managed Care enrollees and 63 were MO HealthNet Fee-for-Service participants. The Managed Care group had a slightly higher rate of dentures with .26 children per 1,000 enrollees having a denture claim and the MO HealthNet Fee-for-Service group having a rate of .20 children per 1,000 participants.

A total of 18,873 MO HealthNet children had encounter claims for extractions during SFY2008. Of these 12,388 were Managed Care enrollees and 6,485 were MO HealthNet Fee-for-Service participants. The MO HealthNet Fee-for-Service group had a lower rate of extractions with 20 children per 1,000 participants and the Managed Care group having a rate of 33 children per 1,000 enrollees.

Adolescent Well-Care Visits Performance Improvement Project (PIP): Figure 9 presents trended annual HEDIS AWC data for each health plan, stratified by service region. The NCQA national Medicaid mean for each measurement year was included as a benchmark reference.

2007 – The statewide and individual health plan goal was to meet or exceed the 2007 NCQA national Medicaid mean of 42.14%. The statewide plan average AWC visit rate of 35.68% did not meet the NCQA national Medicaid mean of 42.14%.

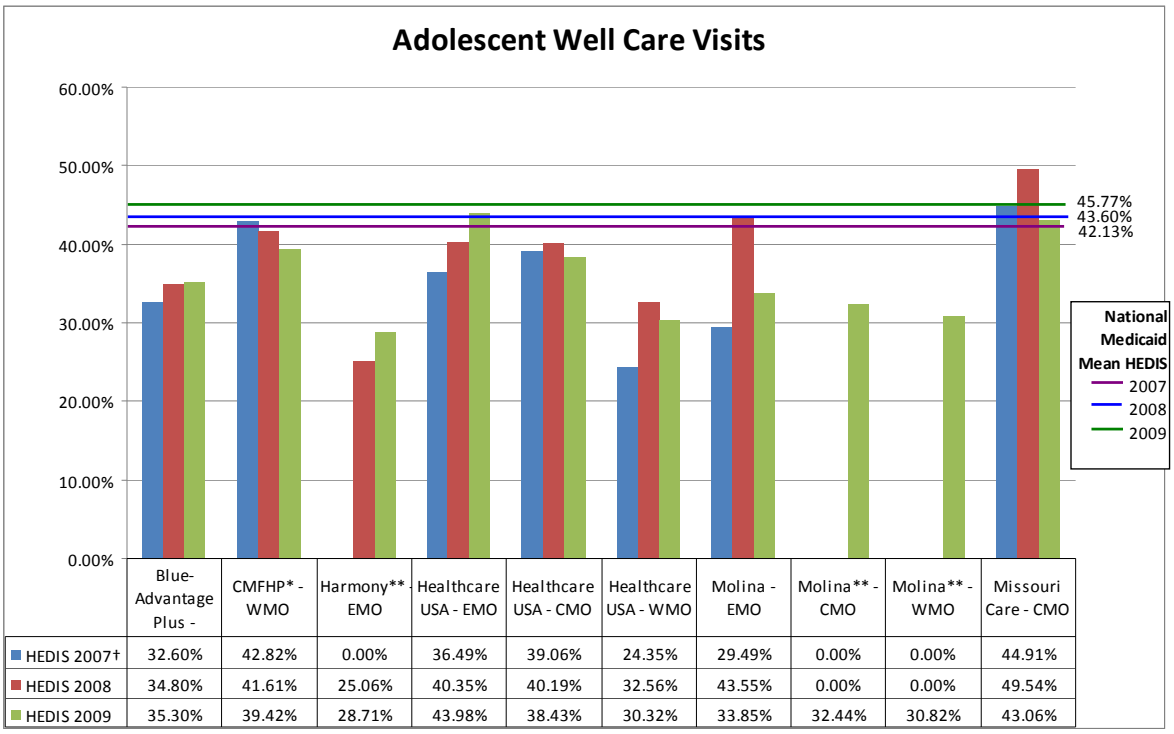
CMFHP, which is located in the Western region, met the statewide and national Medicaid mean goal with an AWC rate of 42.82% (95% CI =34.57% to 44.26%)[1]. Missouri Care, which at the time of the study was located only in Central region, also met the statewide and national Medicaid mean goal with a rate of 44.91% (95% CI = 40.10% to 49.71%).

[1] Confidence Intervals (CI) are estimates of measurement reliability. If the health plan's 95% lower and upper confidence limits included the national Medicaid mean percentage, the rates were considered statistically equal to the national mean. If the national Medicaid mean fell outside of the health plan's CI, the health plan's rates were considered significantly different – higher or lower – than this goal.

2008 - The statewide and individual health plan goal was to meet or exceed the 2008 NCQA national Medicaid mean of 43.60%. The statewide average of 33.41% did not meet the National Medicaid mean of 43.60%. Two health plans met the goal. Molina health plan met the goal with a rate of 43.55% in the Eastern region (95% CI = 38.64% to 48.47%). Missouri Care's Central region rate of 49.54% significantly exceeded the national mean, and was statistically equivalent to the national 75th percentile of 51.39% (95% CI = 44.71% to 54.37%).

2009 - The statewide and individual health plan goal was to meet or exceed the 2009 NCQA national Medicaid mean of 45.77%. The statewide average of 35.82% did not meet the goal of 45.77%. Missouri Care's Central region rate of 43.06% was statistically equal to the goal (CI = 38.27 to 47.84%), as was Healthcare USA's Eastern region rate of 43.98% (95% CI = 40.33% and 49.95%).

MO HealthNet Managed Care Health Plan HEDIS Adolescent Well Care Visit rates --- Percent of Enrolled Members ages 12-21 who had at Least One Well-Care Visit with a PCP or OB/GYN**
(Figure 9)



	Blue-Advantage Plus -	CMFHP* - WMO	Harmony** - EMO	Healthcare USA - EMO	Healthcare USA - CMO	Healthcare USA - WMO	Molina - EMO	Molina** - CMO	Molina** - WMO	Missouri Care - CMO
HEDIS 2007†	32.60%	42.82%	0.00%	36.49%	39.06%	24.35%	29.49%	0.00%	0.00%	44.91%
HEDIS 2008	34.80%	41.61%	25.06%	40.35%	40.19%	32.56%	43.55%	0.00%	0.00%	49.54%
HEDIS 2009	35.30%	39.42%	28.71%	43.98%	38.43%	30.32%	33.85%	32.44%	30.82%	43.06%

* Children's Mercy Family Health Partners
** Harmony did not have a sufficient population for NCQA audited reporting in HEDIS 2007. Molina did not have a sufficient population for NCQA audited reporting in HEDIS 2007 and HEDIS 2008.
† HEDIS measurement years reflect prior calendar year performance (e.g. HEDIS 2007 is CY 2006).

The Adolescent Well-Care PIP has been formally replaced by the Oral Health PIP, but the MCOs continue to evaluate the effectiveness of their initiatives and the measure continues to be monitored by the individual MCOs as they track adolescent well care rates. MCO specific interventions continue to be completed on an annual basis to

increase adolescent well care rates. The MCOs' regional score for Adolescent Well-Care Visits is used in the Auto-Assignment Process.

Behavioral Health Indicators

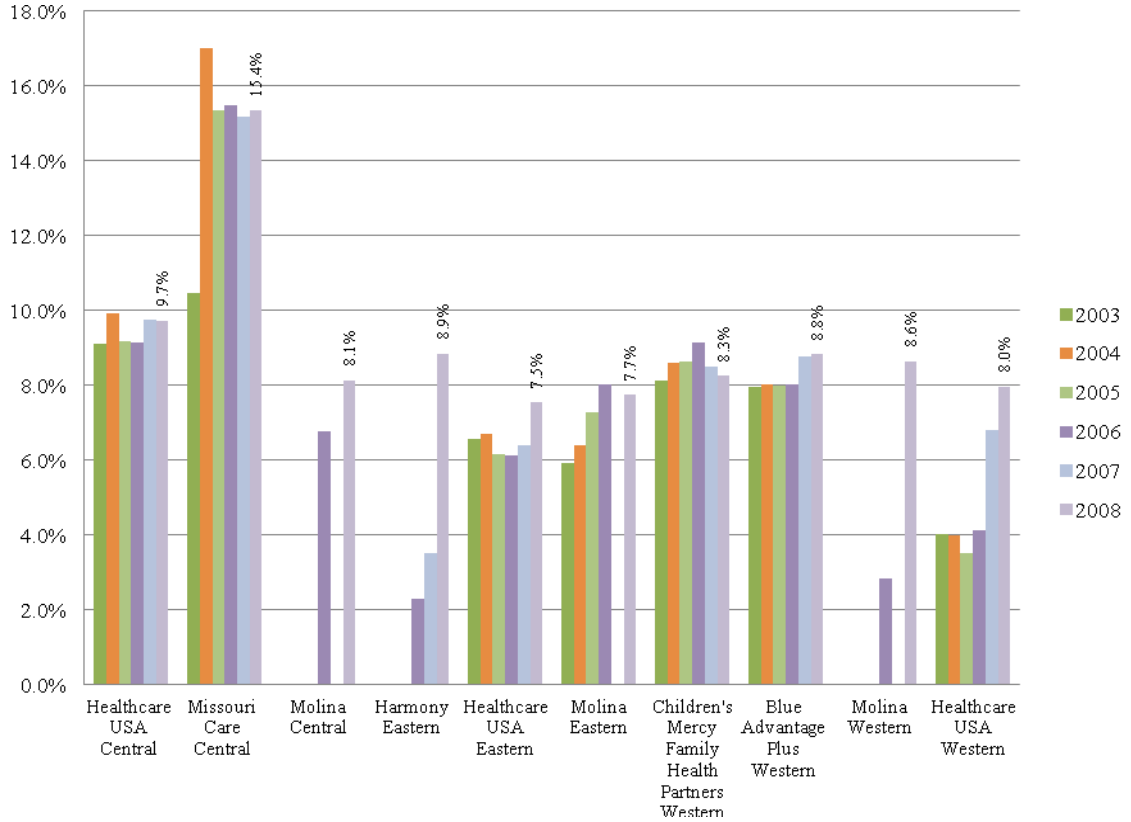
The Behavioral Health Subgroup of the QA & I Advisory Group has continued to track and trend behavioral health indicators through CY 2008 for each of the MCOs. Aggregate data submitted by MCOs and their subcontracted Behavioral Health Organizations (BHOs) (Figure 10)) for selected indicators were reviewed to examine access and use of mental health and substance abuse services among the Managed Care enrollees. MCO to MCO comparison data were available and are presented along with available benchmark data (Figures 11 through Figure 17).

MCO Behavioral Health Organizations (BHO)
(Figure 10)

MCO	BHO
Eastern MO HealthNet Managed Care Region	
Molina Healthcare of Missouri	Mental Health Network
Harmony Health Plan of Missouri	Harmony Behavioral Health
HealthCare USA of Missouri, LLC	Mental Health Network
Central MO HealthNet Managed Care Region	
HealthCare USA of Missouri, LLC	Mental Health Network
Molina Healthcare of Missouri	Mental Health Network
Missouri Care Health Plan	Missouri Care Behavioral Health
Western MO HealthNet Managed Care Region	
Blue-Advantage Plus of Kansas City	New Directions Behavioral Health
Children's Mercy Family Health Partners	New Directions Behavioral Health
HealthCare USA of Missouri, LLC	Mental Health Network
Molina Healthcare of Missouri	Mental Health Network

Figure 11 shows the total behavioral health penetration rates (penetration is a measure of the percentage of plan members accessing behavioral health services through Managed Care). For 2008, the rate of penetration ranged from 7.50% to 15.40% across all ages. During calendar year 2008, four MCOs showed an increase in behavioral health penetration rates from 2007 to 2008 and two showed a decrease. One Western Region One Western Region MCO remained stable.

Total Behavioral Health Penetration Rates, Managed Care Program
(Figure 11)

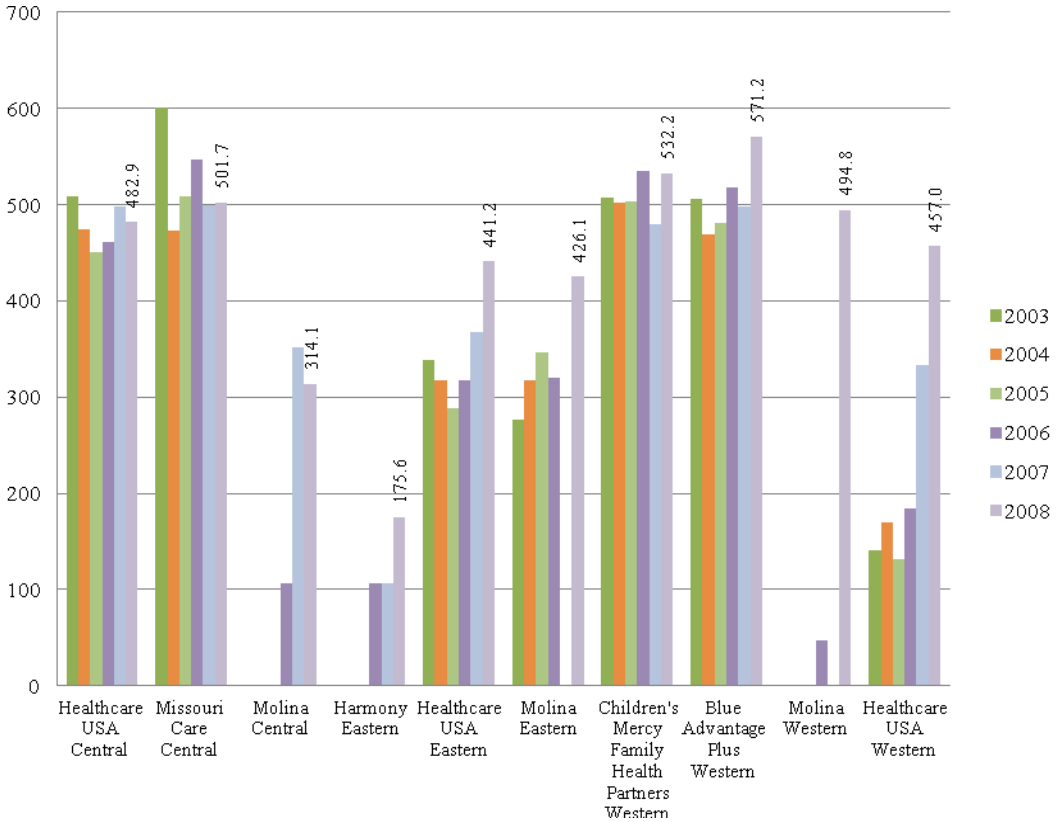


*Community Care Plus purchased Mercy Health Plan's Medicaid book of business effective July 1, 2006 and changed its name to Mercy CarePlus. Molina Healthcare of Missouri, Inc. purchased Mercy CarePlus' Medicaid book of business effective October 1, 2008.

Source: Missouri Departments of Mental Health and Social Services, Behavioral Health Task Force-a subgroup of the Quality Assessment and Improvement Advisory Group for the Managed Care Program, 2008

Figure 12 shows the number of outpatient visits per 1,000 Managed Care enrollees. The range in outpatient visits per 1,000 Managed Care enrollees in 2008 was 175.6 to 571.2. In the Central Region one increased and two decreased in 2008. In the Eastern Region, two MCOs decreased and one did not report for 2007. In the Western Region, three increased and one did not report for 2007. For all three regions, the rate of outpatient visits per 1,000 Managed Care enrollees increased from 2007 to 2008.

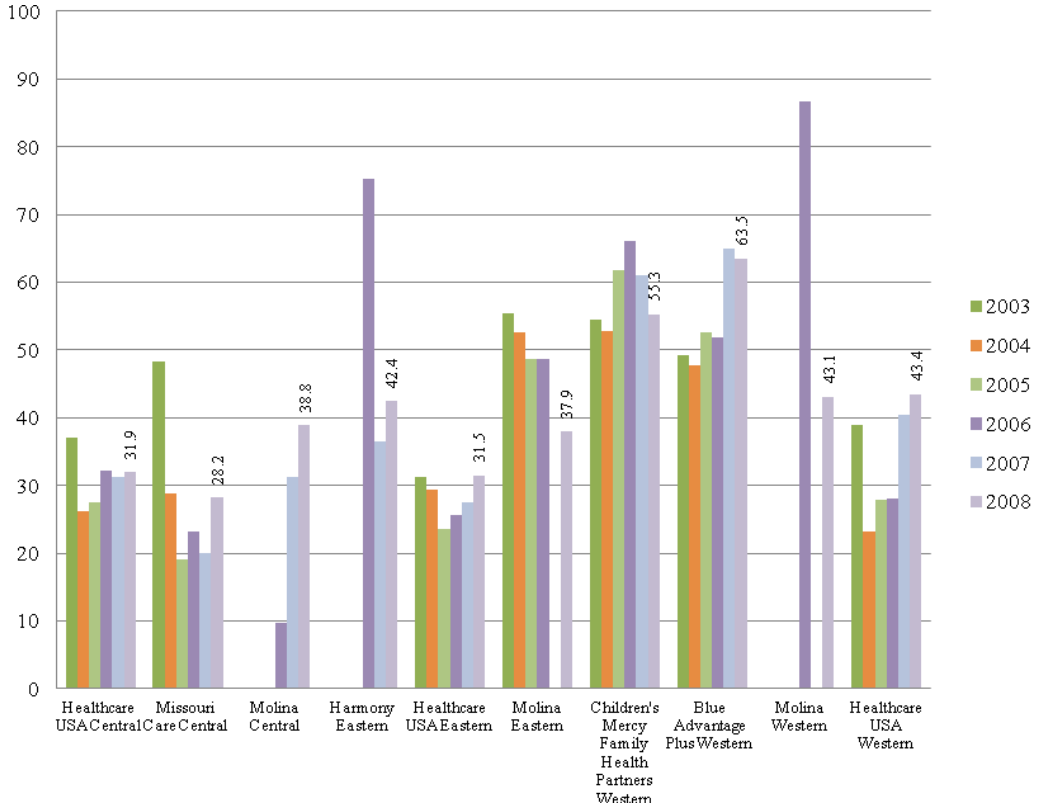
Behavioral Health Outpatient Visits per 1,000 Managed Care Enrollees, Managed Care Program (Figure 12)



Source: Missouri Departments of Mental Health and Social Services, Behavioral Health Subgroup of the Quality Assessment and Improvement Advisory Group for the Managed Care Program, 2008. Note: BHO = Behavioral Health Organization.

Figure 13 shows the rate of mental health inpatient days per 1,000 from 2003 to 2008 for each of the MCOs. The range in inpatient per 1,000 Managed Care Enrollees in 2008 was 28.2 to 63.5. In the Central Region all three MCOs increased. In the Eastern Region two increased and one did not report during 2007. In the Western Region two decreased, one increased, and one did not report during 2007. For all three regions the rate of inpatient days per 1,000 for Managed Care enrollees increased from 2007 to 2008.

Behavioral Health Inpatient Days per 1,000 Managed Care Enrollees, Managed Care Program
(Figure 13)

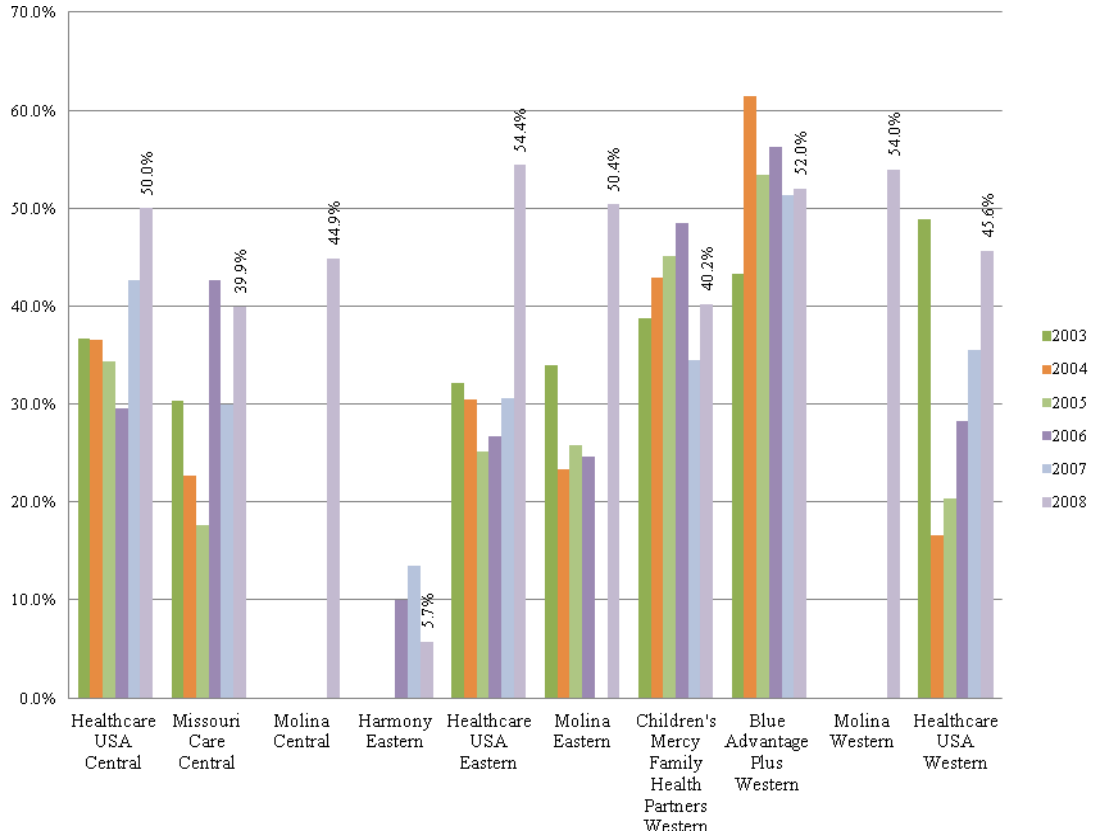


Source: Missouri Departments of Mental Health and Social Services, Behavioral Health Subgroup of the Quality Assessment and Improvement Advisory Group for the Managed Care Program, 2006. Note: BHO = Behavioral Health Organization.

Figure 14 shows the rate of behavioral health ambulatory follow-up visits seven days following hospitalization from 2003 to 2008 for the MCOs. The rate of follow-up visits

at seven days ranged from 5.7% to 54.4%. In the Eastern Region, the rate of ambulatory follow-up visits at seven days increased for one MCO, decreased for one, and one did not report in 2007. Two MCO in the Central Region showed an increase and one MCO one did not report in 2007; and three of the four Western Region MCOs in operation throughout the year showed increases in follow-up rates at seven days following discharge from psychiatric hospitalization, and one did not report in 2007. For all three regions the rate of Behavioral Health Ambulatory Follow-up Visits (7 Days) for Managed Care enrollees increased from 2007 to 2008.

Behavioral Health Ambulatory Follow-up Visits (7 Days) Managed Care Program (Figure 14)

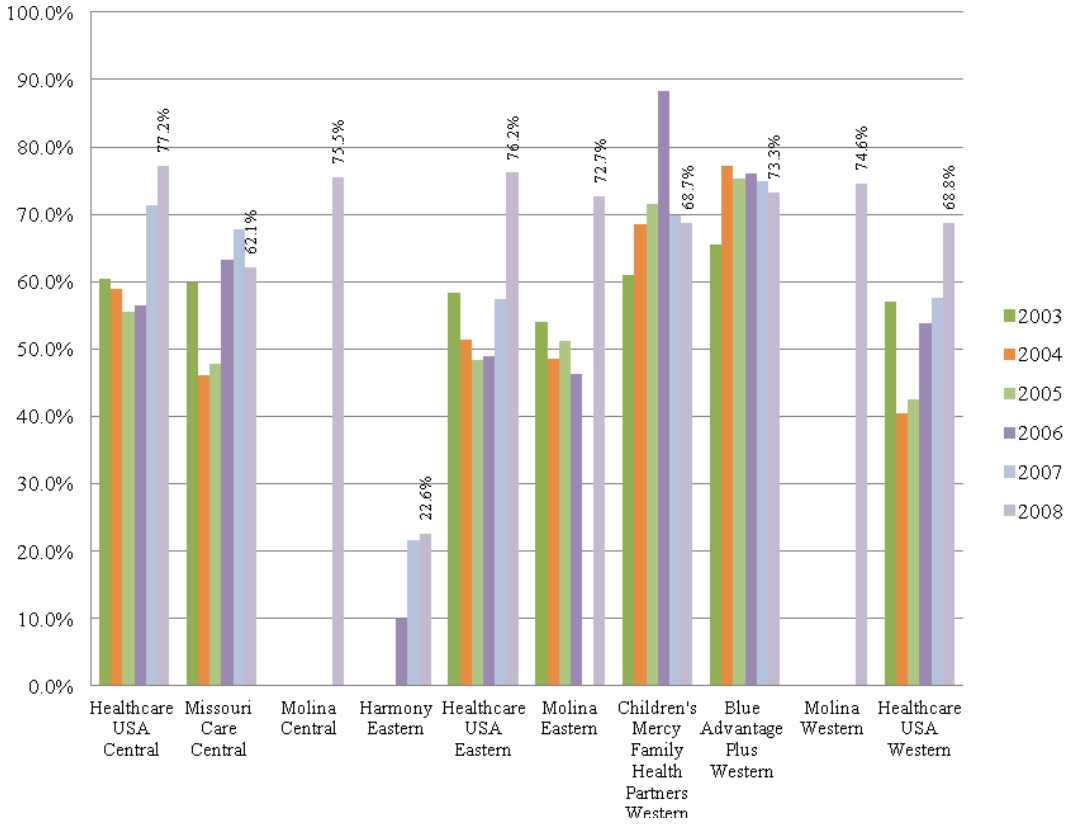


Source: Missouri Departments of Mental Health and Social Services, Behavioral Health Subgroup of the Quality Assessment and Improvement Advisory Group for the Managed Care Program, 2006. Note: BHO = Behavioral Health Organization.

Figure 15 shows the rate of behavioral health ambulatory follow-up visits at thirty days following psychiatric hospitalization for MCOs. The rate in 2008 ranged from 22.6% to 77.2% across MCOs. In the Eastern Region, two of the three MCOs showed increases in

the rate of follow-up visits at thirty days and one did not report in 2007; in the Central Region, one MCOs showed an increase, one decreased and one did not report in 2007; and in the Western Region, two MCOs showed an increase, one showed a decrease and one did not report in 2007. For all three regions the rate of Behavioral Health Ambulatory Follow-up Visits (30 Days) for Managed Care enrollees increased from 2007 to 2008.

Behavioral Health Ambulatory Follow-up Visits (30 Days), Managed Care Program (Figure 15)

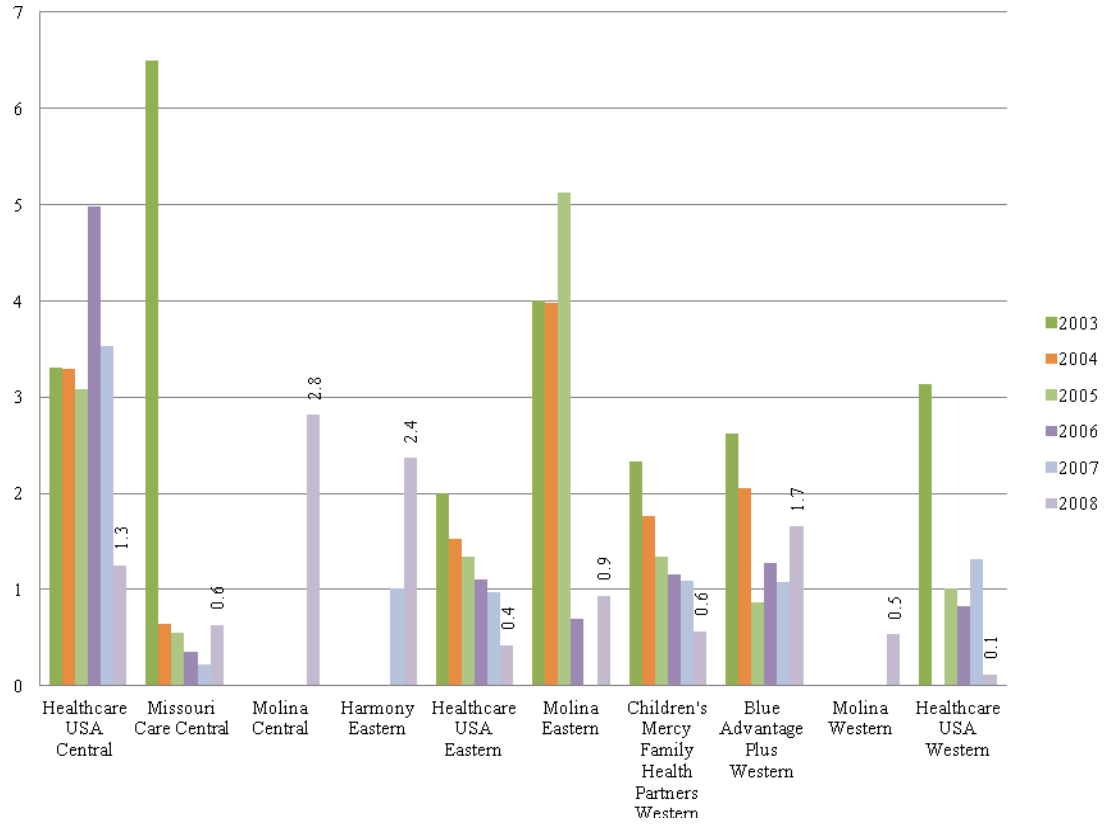


Source: Missouri Departments of Mental Health and Social Services, Behavioral Health Subgroup of the Quality Assessment and Improvement Advisory Group for the Managed Care Program, 2006. Note: BHO = Behavioral Health Organization.

Figure 16 shows the rate of inpatient substance abuse days per 1,000 Managed Care enrollees for MCOs. The rate of inpatient substance abuse days per 1,000 Managed Care enrollees ranged from .1 to 2.8 days per 1,000 Managed Care enrollees in 2008. In the Eastern Region one increased, one decreased and one did not report in 2007. In the

Central Region one MCO increased and two MCOs decreased. In the Western Region one increased, two decreased and one did not report. For all three regions the rate of Inpatient Substance Abuse Days per 1,000 for Managed Care enrollees decreased from 2007 to 2008.

Inpatient Substance Abuse Days per 1,000 Managed Care Enrollees, Managed Care Program
(Figure 16)

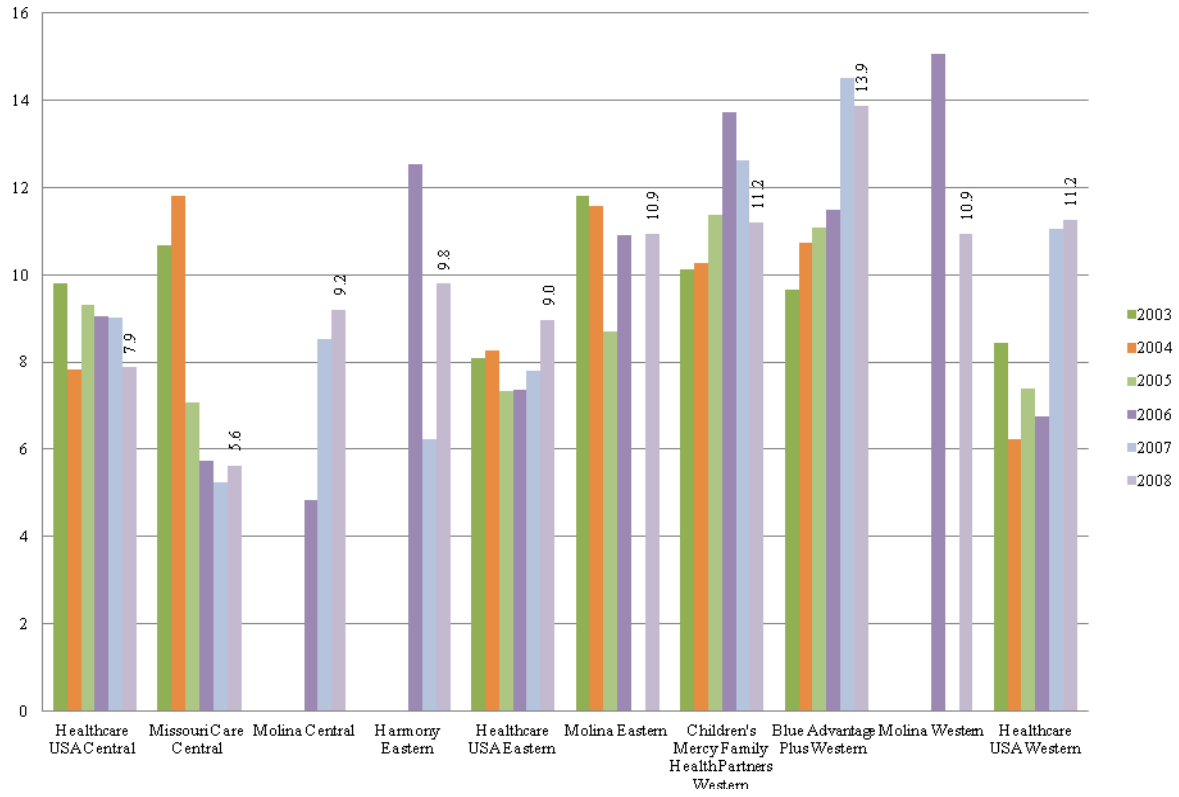


Source: Missouri Departments of Mental Health and Social Services, Behavioral Health Subgroup of the Quality Assessment and Improvement Advisory Group for the Managed Care Program, 2006. Note: BHO = Behavioral Health Organization.

Figure 17 shows the rate of inpatient admissions per 1,000 Managed Care enrollees for MCOs. The rate of inpatient admissions per 1,000 Managed Care enrollees ranged from 5.6 to 13.9 days per 1,000 Managed Care enrollees in 2008. In the Eastern Region two MCOs increased and one did not report in 2007. In the Central Region two MCOs increased and one MCO decreased. In the Western Region one increased, two decreased

and one did not report in 2007. For all three regions the rate of Inpatient Substance Abuse Days per 1,000 for Managed Care enrollees increased from 2007 to 2008.

Inpatient Behavioral Health Admissions per 1,000 Managed Care Enrollees, Managed Care Program
(Figure 17)



Source: Missouri Departments of Mental Health and Social Services, Behavioral Health Subgroup of the Quality Assessment and Improvement Advisory Group for the Managed Care Program, 2006. Note: BHO = Behavioral Health Organization.

Behavioral Health Data Summary: Behavioral Health Inpatient Admissions have increased by 18.8% between 2001 and 2008. Variations in the data between 2001 and 2008 are being evaluated and monitored to determine if there are special cause variations that can be identified. Inpatient days per 1,000 increased by 5.3% from 2007 to 2008. However, it is notable that the average length of stay decreased slightly in 2008, such that the increase in inpatient days can be attributed to the higher number, not increased duration, of inpatient stays.

The Behavioral Health Task Force, a subgroup of the MO HealthNet QA&I Advisory Group, continues to analyze and evaluate behavioral health utilization data with a specific focus on problems identified. Findings are reported at the QA&I Advisory Group and the All Plan Meeting.

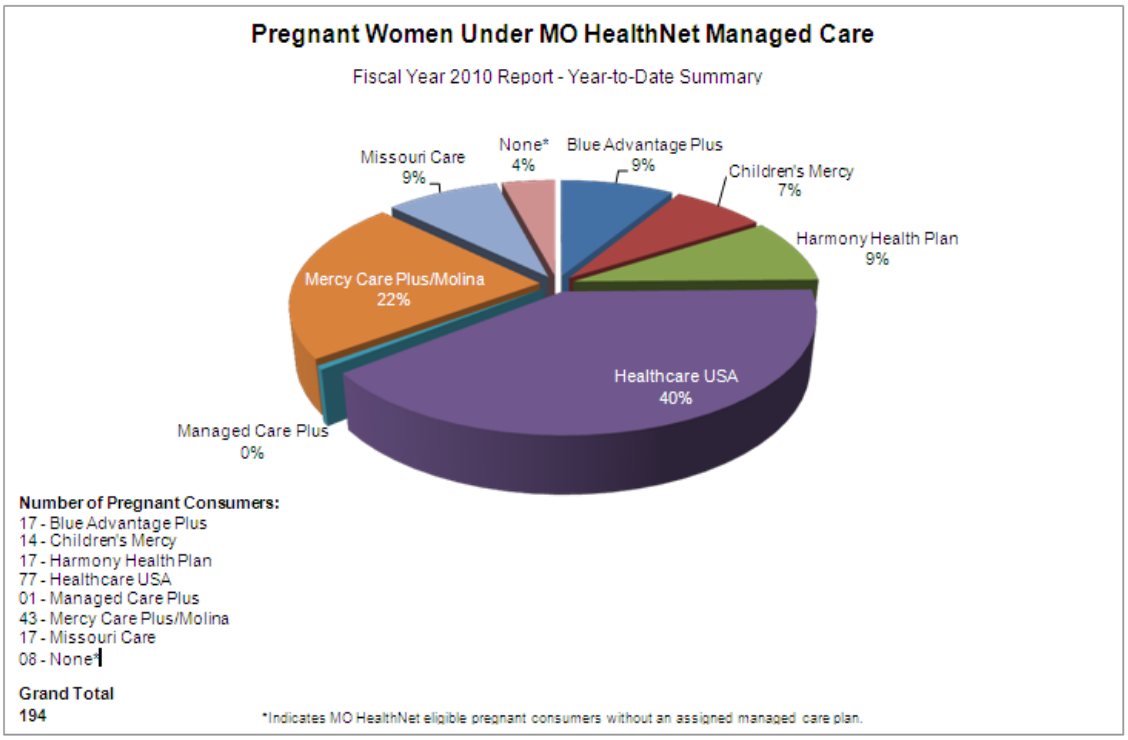
Substance Abuse Treatment Referral Protocol (CSTAR Program) for Pregnant Women Under MO HealthNet Managed Care

Modifications are made to the pregnancy monitoring referral process to enhance communication between treatment providers and the managed care plans such as the new form "Verification of Consumer Consent to Information Release and Communication with Managed Care Health Plan" which was implemented to facilitate the process; in addition to continued utilization of the "Multi-Party Consent" form.

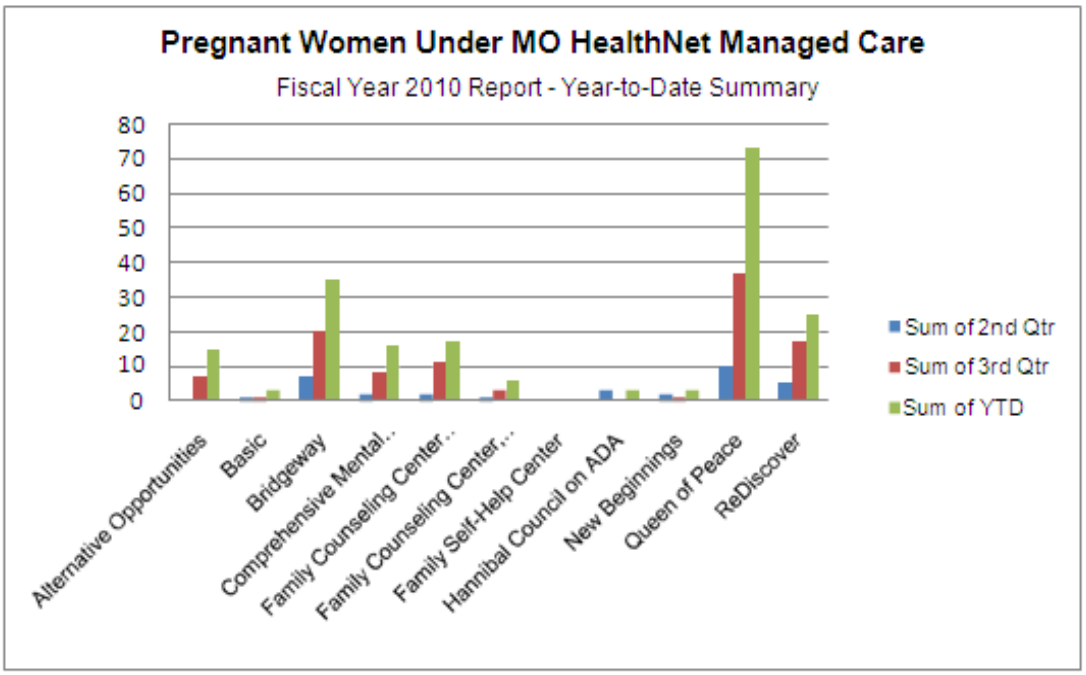
Figures 18, 19, and 20 provide a year to date summary of the number of pregnant members by health plan accessing the CSTAR Program, the facilities at which the members are receiving services, and the referral sources.

Ongoing education and technical assistance is provided on behalf of the Department of Mental Health (DMH) to the treatment providers to increase awareness/understanding of the protocol and to further streamline the direct referral process between the treatment providers and the managed care plans.

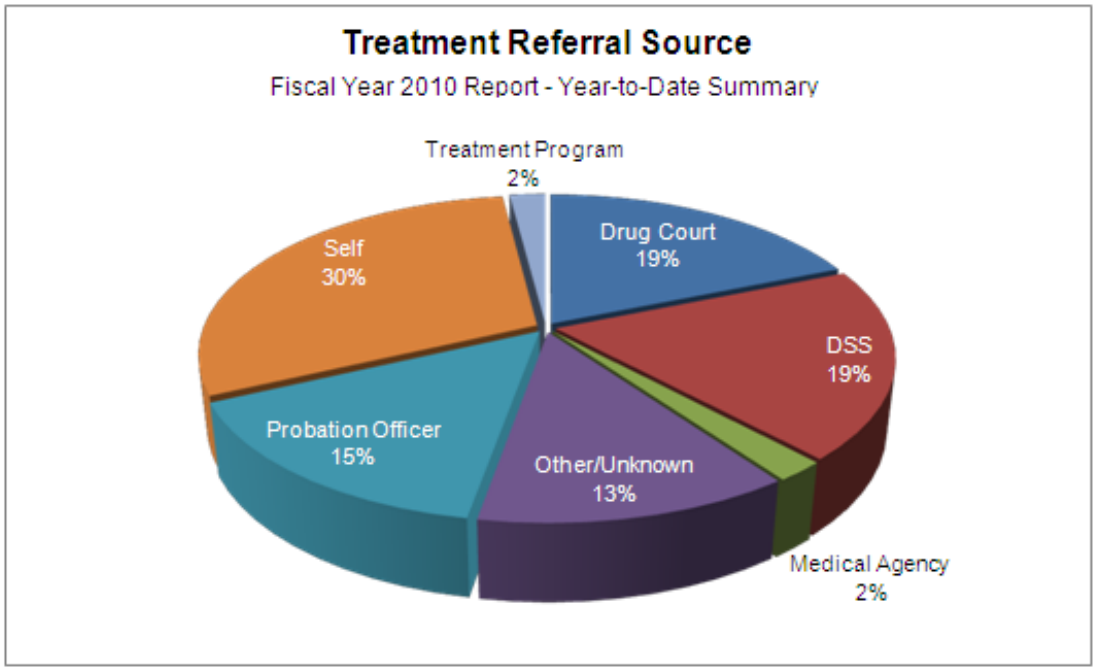
(Figure 18)



(Figure 19)



(Figure 20)



II. Assessment

The State is required by (42) CFR 438.202(d) to assess how well the Managed Care Program is meeting the objectives through analysis of the quality and appropriateness of care and services delivered to enrollees, the level of contract compliance of the MCOs and by monitoring MCO activities on an on-going or periodic bases.

A. Quality and Appropriateness of Care and Services

Missouri assesses the quality and appropriateness of care delivered to the MO HealthNet members through collection and analysis of data from many sources. The MCOs are required to have information systems capable of collecting, analyzing, and submitting the required data and reports. The External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC) ensures the accuracy and validity of the data submitted to the State on an annual basis.

Procedures for Race, Ethnicity, Primary Language, and Data Collection

The Managed Care contract includes language requirements compliant with Federal regulations.

- ***Data collection:*** Missouri updated its procedures for collecting racial and ethnic data consistent with the Office of Management and Budget (OMB) revised standards via Administrative Notice (A-14-2003) on September 11, 2003. Missouri follows the guidance presented in the Notice for obtaining information when individuals fail to self-identify themselves. The two ethnic categories are: Hispanic or Latino and Non Hispanic or Latino. The five racial categories are: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.

  During the application process, the applicant identifies race, ethnicity, and primary spoken language. Race and language are communicated to the MCOs on the daily enrollment file.

- ***Communication with MCOs****:* The MCOs are notified of member enrollment/disenrollment information via a nightly enrollment file and a weekly enrollment reconciliation file. The nightly enrollment file is electronically transmitted and includes members who are newly enrolled, members who transferred into the MCO, and members who are no longer enrolled with the MCO. The weekly enrollment reconciliation file is a snapshot of enrollment at the end of the week. To facilitate care delivery appropriate to member needs, the enrollment file also includes primary language spoken and selective health information. The MCOs utilize information on language to provide interpretive services, develop educational materials for employee training, and facilitate member needs in the context of their language requirements.

Encounter Data Validation

Encounter data is used by the State for rate setting and quality improvement evaluation. Before MCO encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields (e.g., diagnosis and procedure codes, units and dates of service, member and provider identifiers) are complete (each field contains information),

accurate (the information contained in each field is of the right size and type), and valid (the information represents actual dates or procedure and diagnosis codes). Several critical fields for each of six claim types (Medical, Dental, Home Health, Inpatient, Outpatient Hospital, and Pharmacy) are identified by the State and examined by the EQRO for completeness, accuracy, and validity using an extract file from State paid encounter claims.

To examine the extent to which the State encounter claims database is complete (the extent to which State encounter claims database represents all claims paid by MCOs); the level and consistency of services is evaluated by examining the rate of each of six claim types. Additionally, the representativeness (or completeness) of the State encounter claims database is examined by comparing data in the State encounter claims database to the medical records of members. A random sample of medical records is used to compare the diagnosis codes, procedure codes, drug name dispensed, and drug quantity dispensed in the State encounter claims database with documentation in the member medical records. The findings of these comparisons are used to determine the completeness of the State encounter claims database in regards to the medical records of members. The completeness of the State paid encounter claims is then compared with MCO records of paid and unpaid claims.

Required Performance Measures

Managed Care performance measures are required to be reported in accordance with HEDIS specifications to the DHSS and MHD per State regulation 19 CSR 10-5.010 and the MO HealthNet Managed Care contract. Both DHSS and MHD analyze the performance measures to compare MCOs' performance to the statewide average.

DHSS staff produces secondary source performance measures using information reported to them through other sources (i.e. hospitals).

Additional HEDIS measures and behavioral health measures are required by the MHD.

Performance measures provide information regarding direction and trends in the aspects of care being measured. This information is used to focus and identify future quality activities and interventions for existing quality activities. For measures progressing toward or meeting goals, ongoing measurement with barrier analysis may continue. Measures meeting goals continue to be measured to ensure improvement is maintained.

The performance measures are used to monitor grievances, timely access, coordination/continuity, quality of care to ensure delivery of quality health care services.

Three performance measures are validated during the annual EQR process.

A comprehensive list of measures is identified in the Quality Improvement Strategy--Quality Strategy Objectives and Results section.

Clinical Practice Guideline

The MCOs utilize evidence-based clinical practice guidelines that have been formally adopted by the MCOs' Quality Management/Quality Improvement (QM/QI) committee or other clinical committee to support the plan of care.

The state agency has established the following Clinical Practice Guidelines for the MCOs;

- For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, MCOs must use the same criteria as the MO HealthNet Fee-For-Service Program.
- For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, MCOs must use the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). If the member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, MCOs must continue to authorize inpatient care. In the event of disagreement, MCOs must provide full detail of its scoring of the LOCUS/CALOCUS to the provider of service.

Provider Network Reports

The MCOs are required to annually submit network files as part of the annual access plan as required by the Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP). Information on these reports is available at http://difp.mo.gov/. When the MCOs attain NCQA accreditation, the MCO shall continue to submit network files and the access plan as outlined in DIFP regulations.

In addition, the MCOs update the provider network file at the time of any change and as required in the Health Plan Record Layout Manual available at *http://manuals.momed.com/edb_pdf/Health%20Plan%20Record%20Layout%20Manual.pdf*.

MCO Quality Improvement Strategy

Each MCO must meet program standards for monitoring and evaluation of systems as outlined in the Managed Care contract to meet Federal and State regulations. Each MCO must implement a Quality Improvement (QI) Strategy that includes components to monitor, evaluate, and implement the contract standards and processes to improve:

- Quality management;
- Utilization management;
- Records management;
- Information management;
- Care management;
- Member services;
- Provider services;
- Organizational structure;
- Credentialing;
- Network Performance;
- Fraud and abuse detection and prevention;
- Access and availability; and

- Data collection, analysis and reporting

The frequency and types of reports include:

- Monthly Reports: Monthly reports regarding special needs and lead poisoning prevention are submitted to MHD in a format specified by the state agency and are due the last working day of each month.
- Quarterly Reports: Quarterly reports of member grievances and appeals; provider complaints, grievances, and appeals; and fraud and abuse detection are submitted to MHD in a format specified by the state agency.

Annual Evaluation: An annual evaluation of the MCOs' quality assessment and improvement program specific to the Managed Care Program is submitted in the format specified by the state agency. The evaluation contains information concerning the effectiveness and impact of the MCOs' quality assessment and improvement strategy. The annual evaluation report provides information indicating that data is collected, analyzed, and reported, and health operations are in compliance with State, and Federal law and Managed Care contractual requirements. The annual evaluation of the MCOs' QA&I Program incorporates multiple year outcomes and trends. Additionally, the evaluation shows the MCOs' QA&I Program is ongoing, continuous and based upon evaluation of past outcomes. At a minimum, the evaluation contains information from subcontractors and internal processes including:

- An analysis and evaluation of member grievances and appeals and provider complaints, grievances, and appeals;
- An analysis and evaluation of how the MCO incorporates race, ethnicity, and primary language into its quality strategy. The DSS asks each potential enrollee his/her race, ethnicity and primary language at the time of application in accordance with Medicaid eligibility rules. DSS uses the federally recognized categories for race, ethnicity and language. The state agency electronically provides race, ethnicity and language to the MCOs upon member enrollment.
- An analysis and evaluation of utilization and clinical performance data that supports use of evidenced based practice;
- An analysis and evaluation of 24 access/after hours availability, appointment availability and open/closed panels;
- An analysis and evaluation of the MCOs' provider network including provider/enrollee ratios;
- An analysis and evaluation of all Managed Care quality indicators:
  - Trends in Missouri Medicaid Quality Indicators provided by the Department of Health and Senior Services (DHSS);
  - HEDIS Indicators by MCOs Within Regions, Live Births provided by the Department of Health and Senior Services (DHSS) and
  - Managed Care Performance Measures.
- An analysis and evaluation of quality issues and actions identified through the quality strategy and how these efforts were used to improve systems of care and health outcomes;
- An analysis and evaluation of action items documented in the meeting minutes of the MCOs' quality and compliance committee(s) including:

- Trends identified for focused study; results of focused studies; corrective action taken; evaluation of the effectiveness of the actions and outcomes.
- An analysis and evaluation of Performance Improvement Projects (PIPs) that addresses clinical and non-clinical PIPs and the requirement for on-going interventions and improvement;
- An analysis and evaluation of subcontractor relationships that addresses integration with the Managed MCOs' QA&I Program. This analysis and evaluation is not a replication of the Subcontractor Oversight Annual Evaluation report;
- An analysis and evaluation of the MCOs' fraud and abuse program;
- An analysis and evaluation of care management that includes case management, disease management and care coordination for both medical and mental health services; and
- An analysis and evaluation of the MCOs' claims processing and Management Information System.
- Periodic Reports of Quality and Utilization: The MCOs provide periodic reports regarding case management, quality initiatives, and other quality analysis reports per MHD's request.
- An annual report regarding multilingual services for members who speak a language other than English and the MCOs' methods for communicating with members with visual and hearing impairments and accommodating for the physically disabled. The MCOs' report shall include but not be limited to the following:
  - A count by language of how many members declared a language other than English as their primary language.
  - A summary by language of translation services provided to members (oral and in-person).
  - A count of members identified as needing communication accommodations due to visual or hearing impairments or a physical disability.
  - A summary of services provided to members with visual or hearing impairments or members who are physically disabled (Braille, large print, cassette, sign interpreters, etc.).
  - An inventory by language of member material translated.
  - An inventory of member materials available in alternative formats.
  - A summarization of grievances regarding multilingual issues and dispositions.
- Annual subcontractor oversight reports that reflect the MCOs' monitoring activities in the previous year for each health care service subcontractor and any corrective actions implemented as a result of its monitoring activities. The annual subcontractor oversight reports shall be submitted in the format specified by the state agency.

National Committee for Quality Assurance (NCQA) Accreditation

Effective October 1, 2011, MCOs must be NCQA accredited, at a level of "accredited" or better, for the MO HealthNet product. The MCOs must maintain such accreditation thereafter and throughout the duration of the contract. The State of Missouri will require all future Managed Care contractors to be NCQA accredited.

Consumer Assessment of Health Plans Survey (CAHPS)

The Managed Care contract requires the MCOs to submit member satisfaction data to the DHSS annually. The MCOs conduct the Consumer Assessment of Health Plans Survey

(CAHPS) to meet this requirement. The DHSS analyzes the member satisfaction data and posts the results on the DHSS website http://www.dhss.mo.gov/ManagedCare/.

The State requires the use of the current National Committee of Quality Assurance (NCQA) Consumer Assessment of Health Plans Survey (CAHPS). The survey requirements for the 4.0 H Child CAHPS are documented in State regulation (19 CSR 10-5.010) and may be found at**:** http://www.dhss.mo.gov/ManagedCare**.**

The CAHPS-H is administered annually by an NCQA certified vendor.

The survey is used to monitor choice, marketing, information, grievances, timely access, PCP/specialist capacity, coordination/continuity, provider selection, and quality of care. The survey responses are analyzed to create the CAHPS composite (basic information regarding access, availability, and provider competence) and to measure member satisfaction with care. This information is utilized to identify issues for performance improvement projects.

Performance Improvement Projects

The MCOs conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

MCOs are required by contract to have two active Performance Improvement Projects (PIPs) annually. The MCOs report the status and results of one clinical and one non-clinical PIP to the state agency which must include the state-wide PIP and the MCO designated performance improvement projects. The performance improvement projects:

- Measure performance using objective quality indicators.
- Implement the system interventions to achieve improvement in quality.
- Evaluate the effectiveness of the interventions.
- Plan and initiate activities for increasing or sustaining improvement.
- Complete the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

The MCOs develop and implement PIPs as a result of activities through their quality programs and report results to the State annually. The PIPs are used to monitor grievances, information to beneficiaries, coordination/continuity, and quality of care to ensure compliance with contractual requirements and delivery of quality health care services.

24 Hours/7 Days a Week PCP Availability

MCOs are required to assess the availability of PCPs for 24 hours and 7 days per week availability. The MCO provider representatives and the Quality staff generally perform this task. The tasks include monitoring grievances, provider office site visits, secret shopper calls, interviews with staff, and provider education, if indicated. The MCOs report monitoring results to the State staff. State staff annually evaluate the reports to ensure enrollees have 24/7 access to PCP services.

This information is used to monitor grievances, timely access, PCP/specialist capacity, and provider selection to ensure compliance with contractual requirements and delivery of quality health care services.

External Quality Review

The Federal and State regulatory requirements and performance standards as they apply to MCOs are evaluated annually for the State in accordance with 42 CFR 438.310 (a) and 42 CFR 438.310 (b) by an independent EQRO, including a review of the services covered under each MCO contract for: a) timeliness, b) outcomes, and c) accessibility, using definitions contained in 42 CFR 438.320.

The scope of the annual EQR conducted by the State for includes: a) criteria used to select entities to perform the reviews, b) specification of activities to be performed by the EQRO, c) the circumstances in which the EQR may use other accreditation review results, and d) standards for availability of review results.

Competency and Independence: The EQRO must have and maintain a designated EQR staff that meets Federal and state agency competency requirements as mentioned in 42 CFR 438.354 and 42 CFR 438.356 (b). To ensure competency, the EQRO staff must have demonstrated experience and/or knowledge of:

- Medical record review, data abstraction, and information systems;
- Managed care delivery systems, organizations, and financing;
- Quality assessment and improvement methods;
- Research design and methodology, including statistical analysis;
- EQR practices.
- Experience providing EQR services to state Medicaid and/or Children's Health Insurance Programs (CHIP); and
- MO HealthNet enrollees, policies, data systems, and processes (this information is available at http://www.dss.mo.gov/mhd/index.htm.).

The specification of activities to be performed by the EQRO broadly includes:

- Measurement of quality and appropriateness of care and services,
- Synthesis of results compared to the standards, and
- Recommendations based on the findings.

The EQRO will meet these obligations by utilizing the EQR protocols developed by CMS to perform the mandatory activities required of EQROs as mentioned in 42 CFR 438.352 and 438.358, including:

- Data to be gathered,
- Data sources,
- Activities to ensure accuracy, validity and reliability of data,
- Proposed data analysis and interpretation methods, and
- Documents and/or tools necessary to implement the protocol.

The State ensures that the EQRO has sufficient information for the review from the mandatory and optional EQR-related activities described in 42 CFR 438.350. This information is obtained through methods consistent with established protocols, include

the elements described in the EQR results Section, and results will be made available as specified in the regulation.

Mandatory activities conducted by the EQRO as mentioned in 42 CFR 438.358 include:

- Validation of performance improvement projects;
- Validation of MCO performance measures reported by the MCO and calculated by the State; and
- Review at least every 3 years MCO compliance with standards (except with respect to standards under 42 CFR §438.240(b) (1) and (2), for conducting Performance Improvement Projects and calculations of performance measures, respectively) established by the state agency to comply with the requirements of 42 CFR §438.204(g).

Validation of Encounter Data is the optional activity conducted by the EQRO as mentioned in 42 CFR §438.358.

The EQRO provides an annual external quality review report that meets the requirements of 42 CFR §438.364. The EQRO does not disclose the identity of any enrollee within the report. The EQRO must obtain state agency approval of the format of the final report. The EQRO report is a detailed technical report that describes the manner in which the data from each mandatory and state agency selected optional activity, as noted within 42 CFR §438.358, was aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCOs. The report also includes the following for each mandatory and state agency selected optional activity performed:

- Objectives,
- Technical methods of data collection and analysis,
- Description of data obtained,
- Conclusions drawn from the data, and
- Recommendations for improving the quality of health care services furnished by each MCO.

The EQRO provides this information by:

- Holding a review exit conference with MCO administrative and clinical management staff to address findings and recommendations; and
- Presenting a summary report, including findings and recommendations, at the Managed Care Quality Assessment and Improvement (QA&I) Advisory Committee and the All Plan meetings.

Once the EQRO report is final, the QA&I Advisory Group forms a task force to review the recommendations and provide input back to the QA&I Advisory Group regarding actions needed. Revisions to the Quality Improvement Strategy may be necessary as a result of the findings and recommendations in the annual EQRO Report. The EQRO Reports are available on the Department of Social Services, MO HealthNet Division website: http://www.dss.mo.gov/mhd/mc/pages/eval.htm

B. MCO Regulatory Requirements and Contractual Compliance

As required by 42 CFR 438.204(g) the State must establish standards for MCO contracts regarding access to care, structure and operations and quality measurement and improvement.

Missouri requires the MCOs to have internal quality assurance programs and ensures their compliance by monitoring the MCO performance. In an effort to provide adequate access to Missouri's MO HealthNet population, Missouri monitors the standards for access to care, structure and operations, and quality measurement and improvement listed below. These and other metrics identified throughout the QIS document are incorporated in the MCO contract/RFP which is in accordance with Federal Regulations.

Contract provisions established for the MCOs incorporate specific standards for the elements outlined in 42 CFR 438.204: access to care, structure and operations, and quality measurement and improvement. MCOs are responsible for communicating established standards to network providers and subcontracted benefit management organizations, monitoring provider compliance, and enforcing corrective actions as needed.

Access to Care

Standards for access to care include availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services as required by 42 CFR 438.206. Managed Care Program standards promote early intervention at the appropriate level of care, and ensure that preventive and primary care services are available and accessible to enrollees. MCOs must establish accessibility standards to ensure that each member has a primary care provider (PCP) and access to specialists for medically necessary services. Access standards must address availability of routine appointments and medically necessary specialty care services, appointment follow-up procedures and missed appointments, first prenatal visit, waiting times in provider offices, telephone medical advice, urgent care, and after-hours calls availability for PCPs or appropriate licensed professional under his/her supervision. The following activities and reports document the MHD's endeavors to monitor access to care and status of available services:

Care Coordination/Case Management: MCOs must maintain procedures for monitoring the coordination of care, determining whether case management services are needed, establishing referral processes, initiating and maintaining disease management services, and processing authorizations for members receiving out-of-network services.

MHD works collaboratively with the contracted MCOs to meet requirements in 42 CFR 438.208 for care coordination for individuals with special health care needs. Missouri is a 209 (b) State and does not track individuals with Social Security Income (SSI) as a separate eligibility group. A process was developed and maintained to identify enrollees with special health care needs. This information is communicated to the MCOs monthly. The information contains identifying information regarding enrollees in the following subpopulations: individuals eligible for SSI under Title XVI; individuals in foster care or other out-of-home placement, individuals receiving foster care or adoption subsidy, and

individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the State in terms of either program participant or special health care needs.

The progress made to date has focused on development and implementation of processes for identification and assessment of individuals with special health care needs.

To ensure that MCOs meet the needs of persons with special health care challenges, the State's policies emphasize uninterrupted care. Special attention has been given to transition of care from Fee-For-Service to Managed Care. For example, prior to discontinuing any personal care services, the MCO must work with the State to evaluate the continuing needs of the enrollee.

A communication process has been established with MCO case managers. State staff are in communication with MCO case managers on a frequent basis regarding care issues.

Provider Networks: MCOs must regularly monitor their provider network to ensure that service accessibility standards are being met, that provider listings of panel status (open and closed) are accurate, that members have and use their primary care providers, and that emergency rooms are not being used unnecessarily. As part of this monitoring the MCOs, at a minimum, require their providers to report on the number of members they will take as patients or limitations to the number of referrals accepted and report to the MCO when they have reached eighty-five percent (85%) of capacity. The MCOs have and implement policies and procedures describing their network development and monitoring activities to include methods for ensuring adequate capacity for members.

MCOs notify the state agency within five (5) business days of first awareness/notification of change to the composition of the provider network or the health care service subcontractors' provider network that materially affect the MCO's ability to make available all covered services in a timely manner. At a minimum, the MCO notifies the state agency when there is:

- A decrease in the total number of primary care providers by more than five percent (5%);
- A loss of any hospital regardless of whether the loss will result in the MCO failing to meet the service accessibility standards defined in 20 CSR 400-7.095; or
- Other adverse changes to the composition of the provider network which impair or deny the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity.

Community Advisory Committee(s): MCOs form local committees to maintain community partnerships with consumers, community advocates, and traditional and safety-net providers. MCOs include and involve the Community Advisory Committee in policy decisions related to educational, operational, and cultural competence issues.

Emergency Department Protocols: MCOs must develop and maintain protocols that describe communication and interaction processes and distribute them to emergency

departments. A health professional from the MCO must be available 24 hours per day, seven days per week to coordinate transfer of care in emergent care situations, authorize medically necessary post-stabilization services, and communicate with emergency room personnel.

Written protocols must include plan telephone triage and advice systems, contact person responsible for coordinating services and can be contacted 24 hours per day, instruction and referral procedures, and procedures ensuring continuity of care, and handling assessment determined to have a non-emergent condition.

Geographic Mapping: MCOs must comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 as amended. For those providers not addressed under 20 CSR 400-7.095, the MCOs ensure members have access to those providers within thirty (30) miles unless the MCO can demonstrate to the state agency that there is no licensed provider in that area, in which case the MCOs ensure members have access to those providers within sixty (60) miles. For those providers addressed under 20 CSR 400-7.095 but not applicable to the Managed Care Program (e.g. chiropractors), the MCOs are not held accountable for the travel distance standards for those providers.

MCOs are required to annually submit network files as part of the annual access plan as required by the Missouri Department of Insurance, Financial Institutions, & Professional Registration (DIFP). Information on these reports is available at http://difp.mo.gov/. When the MCO attains NCQA accreditation, they will continue to submit network files and the access plan as outlined in DIFP regulations.

The State annually evaluates the access submitted by the MCOs. The State calculates the enrollee access rate for each type of provider in each county the MCO serves to determine if the average enrollee access rate for each county and the average enrollee access rate for all counties are greater than or equal to ninety percent (90%). The entire Managed Care population is used in the calculation for each MCO.

GeoMapping is performed in accordance with the Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP) requirements which may be found at the following website: www.sos.mo.gov/adrules/csr/current/20csr/20c400-7.pdf

This process obtains monitoring information for timely access and PCP/specialist capacity. The software program produces a report that is analyzed for compliance with State regulation. If deficiencies are noted, a waiver must be obtained or MCOs must perform corrective action until in compliance.

The network composition is analyzed annually to identify if the provider network is capable of meeting the needs of the MCO enrollees. The MCO information is used to monitor grievances, PCP/specialist capacity, timely access, and provider selection. The data is used to ensure compliance with contractual requirements and to ensure quality of health care services.

In addition, the MCOs update the provider network file at the time of any change and as required in the Health Plan Record Layout Manual available at *http://manuals.momed.com/edb_pdf/Health%20Plan%20Record%20Layout%20Manual.pdf*

Structure and Operations

MHD has established contractual standards and processes for evaluating the operational structure and procedures MCOs use for internal and external communication, monitoring and the provision of consultation and technical assistance as required by 42 CFR 438.207.

Structural operations also include the MCO's internal operational systems and processes for monitoring and communicating with the MHD and network providers. Contractual requirements include standards for provider selection, enrollee informing, confidentiality, enrollment disenrollment, grievance systems, and subcontracted and delegated relationships. MHD and the MCOs use the following documentary evidence to demonstrate the establishment and monitoring of structural operations:

Member Handbook: All MCOs must submit a Member Handbook annually for approval prior to distribution to members. The Member Handbook must meet the State's Mandatory language requirements. The Member Handbook must meet regulations regarding print size, readability and understandability of text, describe the full scope of Managed Care covered benefits, all available services, procedures for accessing services and address/phone number for each service location. Member Handbooks are reviewed by MHD contract, policy, and clinical staff.

Fraud and Abuse Detection and Prevention: MCOs are required to have a Compliance Officer to oversee and manage all fraud and abuse and compliance activities. The MCOs provide a quarterly report of fraud and abuse activities to the state agency. The MCOs implement internal controls, policies, and procedures designed to prevent, detect, review, report to the state agency, and assist in the prosecution of fraud and abuse activities by providers, subcontractors, and members. The policies and procedures articulate the MCOs' commitment to comply with all applicable Federal and State standards. In order to implement the above, the MCOs must submit a written fraud and abuse plan to the state agency for approval prior to implementation. Any changes to the approved fraud and abuse plan must have state agency approval prior to implementation.

MHD coordinates referral of fraud and abuse issues that occur within the Managed Care program and contracted MCOs. Member and provider complaints and cases submitted by MCOs are forwarded to the MO HealthNet Program Integrity Unit (PIU) for further investigation. The PIU has the authority to refer suspected fraud and abuse to the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office or the Office of Inspector General (OIG).

The PIU has recently began working collaboratively with MFCU to provide technical assistance, to conduct educational trainings for MCOs about the prevention, detection,

reporting and investigation of fraud and abuse and to facilitate opportunities for sharing best practices.

Member Grievance and Appeal Logs: MCOs are required to provide quarterly reports of member grievances and appeals; provider complaints, grievances, and appeals; and fraud and abuse detection to MHD. MHD staff analyzes the quarterly reports for trends and areas of concern.

MHD's focus when reviewing MCOs' quarterly grievance reports is determining whether MCOs are tracking and resolving grievances as required by state regulations and their contracts with the state of Missouri and understanding the degree to which members are accessing the avenues available to them for resolving problems.

Participant Services Unit: The MHD Participant Services Unit (PSU) has administrative responsibility for coordinating all State hearing requests submitted by Managed Care beneficiaries enrolled in MCOs. The PSU utilizes a contracted translation service to serve the needs of non-English speaking members.

Contract Compliance Unit: The MHD Contract Compliance Unit (CCU) investigates, consults with MHD clinical staff, and works to resolve complaints made by enrolled plan members about MCOs. MCO members may make complaints directly to the MHD via email at: Ask.MHD@dss.mo.gov.

The CCU serves as a resource for members in various ways, such as assisting with resolution of issues members have with their MCO, conducting impartial investigations of member complaints, assisting with urgent enrollment and disenrollment processes, and providing education about effective navigation through the Managed Care system.

Utilization Management: MCOs must develop, implement, continuously update and improve their Utilization Management (UM) program to ensure that they consistently use appropriate processes to review and approve the provision of medically necessary covered services.

Responsibilities include ensuring qualified staff for the UM program; separation of medical decisions from fiscal and administrative management; and established criteria for approving, modifying, deferring or denying requested services. MCOs must have internal mechanisms to track and monitor prior authorization, timeliness of determination, and a process to integrate reports on review of number and types of appeals, denials, deferrals and modifications.

Quality Measurement and Improvement

MCO contracts require an ongoing program for quality assessment and performance improvement of the services provided to enrollees as required in 42 CFR 438.240. Quality measurement and improvement standards include clinical practice guidelines, quality assessment and performance improvement program, and health information systems. The clinical practice guidelines used by MCOs and providers are nationally recognized and accepted, based on valid and reliable clinical evidence and applicable to

the populations served within the Managed Care Program. Quality improvement projects are designed to achieve ongoing measurement and intervention, significant improvement sustained over time in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

Clinical Practice Guidelines: The MCOs utilize evidence-based clinical practice guidelines that have been formally adopted by the MCOs' Quality Management/Quality Improvement (QM/QI) committee or other clinical committee to support the plan of care.

The state agency has established the following Clinical Practice Guidelines for the MCOs;

- For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, MCOs must use the same criteria as the MO HealthNet Fee-For-Service Program.
- For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, MCOs must use the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). If the member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, MCOs must continue to authorize inpatient care. In the event of disagreement, MCOs must provide full detail of its scoring of the LOCUS/CALOCUS to the provider of service.

HEDIS: To assess the quality of care provided to Managed Care members, as federally required, MHD requires contracted MCOs to annually report Managed Care performance measures in accordance with HEDIS specifications to the Department of Health and Senior Services (DHSS) and MHD per State regulation 19 CSR 10-5.010 and the Managed Care contract. HEDIS measures are established by the National Committee for Quality Assurance (NCQA) and are the "gold standard" performance measures used nationally to assess the quality of care provided by commercial, Medicaid and Medicare health plans.

The HEDIS measures for MCOs currently focus on access to care provided to pregnant women and children, ambulatory care services provided to members of all ages, screening for diseases such as breast and cervical cancer, and care provided to members with chronic diseases such diabetes and asthma.
MHD shares MCO-specific and aggregate results with the MCOs and publicly releases them on an annual basis. MHD also incorporates MCO results into the *Consumer Guides* provided to potential enrollees, both mandatory and voluntary. These *Consumer Guides* are designed to encourage members to choose an MCO based on the quality of care provided in areas particularly relevant to each member -- such as prenatal and postpartum care, timely childhood immunization, treatment for chronic conditions, and the plan's customer service.

MHD currently uses HEDIS scores for three selected measures (Annual Dental Visits, Adolescent Well Care Visits and Mental Health Utilization) in the Auto Assignment Performance Incentive Program, which awards more defaulted enrollment to MCOs with

higher scores in these measures. During the second year of the contract, there will be a measurement of Emergency Department Visits which is a component of Ambulatory Care, an additional HEDIS measure, and the total evaluation score will be replaced by a measure based upon encounter data and the extent to which it matches with MCO financial data submissions. In the third year of the contract, there will be one (1) additional HEDIS measure (for a total of six (6) HEDIS measures) and the total evaluation score will again be replaced by a measure based upon encounter data and the extent to which it matches with MCO financial data submissions.

MCOs indicate that the public release of HEDIS scores, both in the annual summary report and the *Consumer Guides*, is a strong incentive for MCOs to improve quality particularly because these materials are reviewed not only by members, but also by legislators, advocates and other potential purchasers.

MCO Monitoring

The State has developed a comprehensive program to assess all aspects of MCO performance. The program involves routine analysis and monitoring of performance data submitted by the MCOs; comprehensive on-site behavioral health operational reviews and surveys designed to monitor areas of particular concern such as case management, behavioral health provider availability, and other issues identified through routine monitoring activities. Below are descriptions of the various monitoring activities.

Operational Data Reporting: The MCOs provide the state agency with information concerning uniform utilization, quality assessment and improvement, member satisfaction, complaint, grievance, and appeal, and fraud and abuse detection data on a regular basis. On a periodic basis, the MCOs make available clinical outcome data in areas of concern to the state agency. The MCOs cooperate with the state agency in carrying out data validation steps. The state agency provided standardized report formats and instructions for the MCO to use in reporting the following operational data:

- Fraud and Abuse Activities Reports: The MCOs provide a quarterly report of fraud and abuse activities to the state agency. The report must be submitted in accordance with state agency guidelines contained within the fraud and abuse policy statement.
- Timeliness of Claim Adjudication Report: On a quarterly basis, the MCOs submit to the state agency a "Timeliness of Claims Adjudication Report" in accordance with the quarterly reporting schedule specified by the state agency.
- Quarterly Complaint, Grievance, and Appeal Report: On a quarterly basis, the MCOs submit to the state agency a Quarterly Complaint, Grievance, and Appeal Report, for both member and provider complaints, grievances and appeals.
- Monthly Special Needs: The MCOs submit a monthly special needs report.
- Monthly Lead Poisoning Prevention: The MCOs submit a monthly lead poisoning prevention report.
- Disease Management Update Report: The MCOs provide the state agency with a quarterly report that includes the total number of members enrolled and disenrolled during the quarter in their disease management programs. The MCOs must have systematic methods of identifying and enrolling members using evidence-based clinical practice guidelines. The MCOs must have established measurable

benchmarks and goals for major depression, asthma and at least one of the following: obesity, diabetes, hypertension, or Attention Deficit Hyperactivity Disorder *(*ADHD*).*

- Annual Verification of Review of Education and Marketing Materials: The MCOs provide the state agency with documentation verifying the MCO reviewed its education and marketing materials and acted upon any required changes.
- Call Center Report: The MCOs submit quarterly reports on the activities of all call center/hotlines (i.e. number of calls, call abandonment rate, average hold time, etc.).

The State continues to work with the MCOs to ensure submission of encounter data, member and provider complaints, grievances, and appeals; detection of fraud and abuse; tracking enrollment; generating administrative data for decision making; reporting lead case management activities in Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC); and assessing MCO contract compliance. The State has assisted the MCOs in meeting compliance review standards for Enrollee Rights by reviewing and standardizing Managed Care Member Handbooks; developing consistency in grievance systems; fraud and abuse systems, and lead case management; and reviewing the Information System Capabilities Assessment (ISCA) reports. The State has provided for ongoing communication with the MCOs through scheduled face-to-face and conference call meetings. Some processes are performed annually, quarterly, and monthly.

MHD analyzes and evaluates data from a variety of sources including the state agency's Medicaid Management Information System (MMIS) to assess the quality and appropriateness of care delivery to the Managed Care population. The following are analyzed and evaluated:

- Monthly reports, quarterly reports, periodic reports, annual reports, and the annual evaluations submitted by the MCOs.
- Encounter data.
- Performance measures.
- Performance improvement projects.
- Compliance with the Managed Care contract.
- Enrollment, transfer and disenrollment activity.

Results from the analysis and evaluation activities are compiled and presented through regularly scheduled meetings of the State Quality Assessment & Improvement Advisory Group. The QA & I Advisory Group will review these results to identify opportunities for improvement.

Member and Provider Complaints, Grievances, and Appeal: MCOs are required to submit quarterly member and provider complaint, grievance, and appeal reports per the Managed Care contract. The MO HealthNet Division (MHD) analyzes the quarterly reports for quality and effectiveness of care and access. The data is compiled into uniform region and statewide reports. In order to accurately compare MCOs and regions, the number of complaints, grievances, and appeals being reported is calculated based on 'per 1000 members' of each MCO's enrollment for the quarter being reported.

The MCO data is primarily utilized to monitor marketing, enrollment/disenrollment, program integrity, information to beneficiaries, timely access, grievances, PCP/specialist capacity, coordination/continuity, coverage authorization, provider selection, and quality of care. The data is analyzed to identify trends; to ensure that quality health care services are provided to enrollees; to ensure MCOs are in compliance with federal, state, and contract requirements; and to contribute to a process that partners with MCOs to improve care. The MCO analysis findings are reported to the QA&I Advisory Group. The advisory group members discuss the findings to identify opportunities for improvement.

The MO HealthNet Division's (MHD) Provider Communications (PCU) and Participant Services Units (PSU) have the responsibility for hotline calls from MO HealthNet participants and providers regarding all aspects of the MO HealthNet Program. These Units refer Managed Care issues to the respective MCO or to MHD's Contract Compliance Unit (CCU). The CCU also received issues from the Ombudsmen Program and written communications from enrollees and providers.

Maternal and Child Health Indicators: The Maternal and Child Health (MCH) Indicators are used to examine the impact of the Managed Care Program on maternal/infant and child health since the inception of the Managed Care Program; and to compare this progress with Non-Medicaid and MO HealthNet Fee-for-Service participant groups.

The *Maternal and Child Health Indicators and Trends Report* is compiled annually by the Department of Health and Senior Services (DHSS) from publicly reported vital health statistics and hospital discharge data sets. Aggregate data from the Managed Care Program baseline (1995 to the present) are available for the maternal/infant and child health indicators.

The Maternal and Child Health Indicators provide a mechanism for examining trends and the significance of trends among the Managed Care enrollee, MO HealthNet Fee-For-Service participants, and the Non-Medicaid (in the Managed Care Program Regions) groups of women and children in Missouri. The comparison of trends within groups over time provides some control over a variety of demographic variables and allows for examining progress over time within groups. Nine maternal/infant health and four child health indicators considered important indices of the impact and progress of the Managed Care Program were selected for analysis.

Geographic Mapping of Provider Network: The State annually evaluates the access submitted by the MCOs. The State calculates the enrollee access rate for each type of provider in each county the MCO serves to determine if the average enrollee access rate for each county and the average enrollee access rate for all counties are greater than or equal to ninety percent (90%). The entire Managed Care population is used in the calculation for each MCO.

GeoMapping is performed in accordance with the Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP) requirements which may be found at the following website: www.sos.mo.gov/adrules/csr/current/20csr/20c400-7.pdf

This process obtains monitoring information for timely access and PCP/specialist capacity. The software program produces a report that is analyzed for compliance with State regulation. If deficiencies are noted, a waiver must be obtained or MCOs must perform corrective action until in compliance.

The network composition is analyzed annually to identify if the provider network is capable of meeting the needs of the MCO enrollees. The MCO information is used to monitor grievances, PCP/specialist capacity, timely access, and provider selection. The data is used to ensure compliance with contractual requirements and to ensure quality of health care services.

External Quality Review: Effective January 1, 2010 Behavioral Health Concepts Incorporated became the EQRO for Missouri. Results of the EQR assure compliance with BBA Regulations and assess the MCOs for compliance with requirements addressed in the Quality Strategy and the MCO contract.

The MCO information is used to monitor information provided to beneficiaries, grievances, timely access, coordination/continuity, coverage authorization, provider selection, and quality of care. Information from the onsite review is used to ensure compliance with contractual requirements and to ensure quality of health care services.

The EQRO areas for improvement are presented to the Quality Assessment and Improvement (QA&I) Advisory Group annually. The QA&I Advisory Group forms a task force to review the areas for improvement and provide input to the QA&I Advisory Group regarding actions needed. The QA&I Advisory Group recommend actions to be taken on the EQRO areas for improvement.

Encounter Data Validation: Encounter claims data are used by the State to conduct rate setting and quality improvement evaluation. Before State encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields (e.g., diagnosis and procedure codes, units and dates of service, member and provider identifiers) are complete (each field contains information), accurate (the information contained in each field is of the right size and type), and valid (the information represents actual dates or procedure and diagnosis codes). Several critical fields for each of six claim types (Medical, Dental, Home Health, Inpatient, Outpatient Hospital, and Pharmacy) were identified by the State and examined by the EQRO for completeness, accuracy, and validity using an extract file from State paid encounter claims. To examine the extent to which the State encounter claims database was complete (the extent to which State encounter claims database represents all claims paid by MCOs); the level and consistency of services was evaluated by examining the rate of each of six claim types. Additionally, the representativeness (or completeness) of the State encounter claims database was examined by comparing data in the State encounter claims database to the medical records of members. A random sample of medical records was used to compare the diagnosis codes, procedure codes, drug name dispensed, and drug quantity dispensed in the State encounter claims database with documentation in the member medical records. The findings of these comparisons were used to determine the completeness of the State encounter claims database in regards to the medical records of members. The

completeness of the State paid encounter claims was then compared with MCO records of paid and unpaid claims. This proved to be a difficult task, as all of the MCOs data submissions did not include unique claim identifiers that could be used to accomplish this comparison, this is not an MCO issue, these unique claim identifiers are not available until a claim is of paid status. All six MCOs provided data in the format necessary to make the comparisons. This was the first year that all MCOs did this correctly.

Behavioral Health Clinical Reviews: The Missouri Department of Social Services' MO HealthNet Division (MHD) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct a clinical performance review of the Behavioral Health Organizations for four (4) of the MCOs in 2008. Staff from MHD and the Department of Mental Health (DMH) conducted a clinical performance review of the behavioral health in-house operations for the two (2) remaining MCOs in 2009. The State in conjunction with the DMH conducts annual follow-up reviews of each MCO and its Behavioral Health Organization.

The focus of the behavioral health reviews was to explore variances in behavioral health utilization and to identify any patterns of under or over-utilization that would suggest issues with access to or quality of care for Managed Care enrollees. The reviews addressed the following areas with respect to utilization:

- Adequacy of quality monitoring systems including oversight of staff performance; caseloads; network access; provider practice patterns; utilization; denial and complaint trends and other quality data.
- Involvement of the Medical Director in utilization and quality management.
- Effectiveness of executive management and MCO oversight and reports.
- Performance on a number of key metrics including telephone response, staff turnover, network access, and utilization and complaint rates.

As a result of the Behavioral Health reviews the QA&I Advisory Group reconvened the Behavioral Health Task Force to address problems identified. The Behavioral Health Task Force formed the following work groups:

- Psychiatric Access,
- Dashboard, and
- Case Management.

The work groups were comprised of MHD, DMH, MCO, Ombudsmen, and Behavioral Health Organization staff and charged with identifying behavioral health dashboard metrics to be reported to the State on a quarterly and/or annual basis. The metrics include, but may not be limited to, the following:

- Number of providers/1,000 members,
- Open and closed psychiatrist panels,
- Appointment availability,
- Penetration rate,
- Outpatient Visits/1000,
- ER visits/1000,
- HEDIS outpatient plus ER visits/1000,
- GeoAccess,

- Inpatient MH Discharges/1000,
- Inpatient SA Discharges/1,000,
- Inpatient MH Days/1000,
- Inpatient Substance Abuse Days/1000,
- Readmission Rates for Members in Case Management,
- Grievances and Appeals Monitoring,
- Case Management Patient Satisfaction Survey, and
- Ambulatory Follow-up after Hospital for Mental Health (7 and 30-day follow-up).

Mechanisms the State Uses to Identify Persons with Special Health Care Needs to MCOs: The special health care needs (SHCNs) population is defined as:

- Children with special health care needs including those with Autism Spectrum Disorder. Children with special health care needs are those children that without services such as private duty nursing, home health, durable medical equipment/supplies, and case management may require hospitalization or institutionalization;
- Individuals qualifying to receive services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a) (1) (D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.

To identify persons with Special Health Care Needs (SHCN's), the Health Benefit Manager (HBM), Infocrossing Healthcare Services, administers the Managed Care Health Risk Assessment (HRA) to the enrollee at the time of enrollment into the MCO. The HBM includes an HRA form for each eligible in the enrollment packet for mail-in purposes and must administer the HRA over the telephone at the time of a telephone enrollment or transfer request. If the mail-in enrollment does not include a completed HRA, the HBM must make an attempt to contact the individual by telephone for the information. There should be a health risk assessment for each eligible in the household. The completed HRAs are provided nightly to the MCOs as they are collected.

The HRA provides the MCO with important information about the health risks of new enrollees. By providing opportunities for early identification of enrollees who are pregnant; have SHCNs; conditions such as asthma, diabetes, high blood pressure; behavioral health treatment or counseling; substance abuse treatment or counseling; physical, speech, or occupational therapy; or special equipment (for example: to help with moving, walking, talking, hearing, breathing, feeding, personal care, etc.) assessments may be made for referral to case management or disease management.

The MCOs have developed condition specific detailed assessment forms. Based upon assessment results and in partnership with the member, a more detailed care plan may be developed or the appropriate frequency of follow–up outreach identified. Follow-up care may include, specialist referrals, accessing durable medical equipment, medical supplies, and home health services. Where appropriate, case managers will provide coordination and continuity of services to enrollees. MCOs are required to complete a treatment plan for all beneficiaries meeting the requirements of persons with special health care needs as

defined above. All treatment plans must comply with the regulations found in federal regulations at 42 CFR 438.208, including requirements for direct access to specialists.

MCOs are required to have in place mechanisms to assess the quality and appropriateness of care furnished to all enrollees with particular emphasis on children with special health care needs. These mechanisms may include but are not limited to performance measures and performance improvement projects. MCOs receive a monthly special healthcare needs list from the state agency.

Auto-Assignment Process: As a result of HEDIS analysis over time and in an effort to promote quality, access to services, and continuing improvement in the delivery of health care services to Managed Care enrollees, the random auto-assignment process in the 2009 Managed Care contract was revised to include components based on the total performance score for each MCO.

During the first year of the contract, the performance score was based on the following:

- The total Request for Proposal (RFP) evaluation score determined by the State of Missouri;
- The MCO's Missouri regional score on the HEDIS 2008 measure of annual dental visits;
- The MCO's Missouri regional score on the HEDIS 2008 measure of adolescent well care visits;
- The MCO's Missouri regional score on the HEDIS 2008 measure of mental health utilization;
- The number of FQHCs, RHCs, and CMHCs the MCO has in its network (beyond the minimum of one (1) in the region); and
- The inclusion of an acute care safety net hospital, (as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended) in its network. The MCO received a total number of points based on these six (6) measures; the total of these points is the performance score earned by the MCO. The performance score translates into a percent of the performance auto assignment. For the first year of the contract, MCOs new to the Managed Care Program or new to a region received the average score of all MCOs in the awarded region for its proxy HEDIS 2008 measures.

Each year of the contract, the performance measures included will change and the performance score and auto assignment percentage will be recalculated by the State.

In the second year of the contract, there will be a measurement of Emergency Department Visits which is a component of Ambulatory Care, an additional HEDIS measure, and the total evaluation score will be replaced by a measure based upon encounter data and the extent to which it matches with MCO financial data submissions.

In the third year of the contract, there will be one (1) additional HEDIS measure (for a total of six (6) HEDIS measures) and the total evaluation score will again be replaced by a measure based upon encounter data and the extent to which it matches with MCO financial data submissions.

The State will conduct meetings with stakeholders and the MCOs to solicit input on appropriate measures to be used during the second and third years of the contract. The State will inform the MCOs of the measures to be used at least six (6) months prior to the implementation of the changed performance auto assignment algorithm.

Performance Based on HCY/EPSDT Participant Ratio: In accordance with CMS guidelines, the state agency requires eighty percent (80%) of eligible members to have HCY/EPSDT well child visits and, accordingly, has included an eighty percent (80%) participant ratio in the rates paid to the MCO. In accordance with CMS 416 reporting methodology, the state agency shall measure MCO's performance regarding the percentage of eligible members having HCY/EPSDT well child visits (participant ratio). The state agency applies state specific criteria to the CMS methodology to reflect the Managed Care Program. The state specific criteria reflects performance by Category of Aid and rate cell, the measurement schedule, and recognition of a month to be greater than twenty-seven (27) days. The participant ratio is defined as the number of total eligibles receiving at least one initial or periodic well child visit divided by the number of total eligibles who should receive at least one initial or periodic well child visit.

In the event that the HCY/EPSDT participant ratio is not equal to eighty percent (80%) of eligible members having an HCY/EPSDT well child visit as calculated using the CMS 416 reporting methodology, the state agency shall with five (5) calendar days prior notice make a pro rata adjustment to the monthly capitation payment to the MCO for each percentage point above or below eighty percent (80%), but not to exceed one hundred percent (100%). This pro rata adjustment shall be based on the portion of the monthly capitation payment related to HCY/EPSDT well child visits and shall be applied to each rate cell in which well child visits are required.

If the MCO is new to a Managed Care region, the MCO shall agree that its capitation rate for the first contract year shall reflect the average participant ratio of the MCOs that are not new to the region by rate cell and category of assistance for the applicable measurement period. After the first contract year, the MCO's future capitation rate is adjusted by the MCO's actual 12-month HCY/EPSDT participant ratio.

Sanction-Liquidated Damages for Failure to Provide Covered Services: In the event the state agency determines the health plan failed to provide one or more of the covered services, the state agency shall direct the health plan to provide such service. If the health plan continues to refuse to provide the covered service(s), the state agency shall authorize the members to obtain the covered service from another source and shall notify the health plan in writing that the health plan shall be charged the actual amount of the cost of such service. In such event, the charges to the health plan shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the health plan. With such deductions, the state agency shall provide a list of the members from whom payments were deducted, the nature of the service(s) denied, and payments the state agency made or will make to provide the medically necessary covered services.

Remedies for Failure to Perform Administrative Services: Whenever the state agency determines that the health plan has failed to perform an administrative function required per the requirements of the contract, the state agency shall notify the health plan of the health plan's failure to perform required administrative services pursuant to the requirements of the contract and shall give the health plan five (5) working days to develop an acceptable action plan for correcting the administrative services failure. For the purposes these provisions, "administrative services" are defined as any contract requirements other than the actual provision of covered services.

- If the health plan submits an action plan for correcting the failure and if the plan is acceptable to the state agency, no action shall be taken at that time, provided that the health plan implements the corrective action as approved by the state agency.
- If the health plan fails to submit an action plan within the five working days or if the health plan does not implement the corrective action plan within the time frame stated in the action plan, the state agency shall withhold payment from the next capitation payment due the health plan as stated below:
  - The amount withheld shall be up to three percent (3%) of the total amount of the next capitation payment due the health plan.
  - The state agency shall continue to withhold up to three percent (3%) until successful correction of the administrative services failure by the health plan.
  - After successful correction of the administrative services failure, the state agency shall pay the health plan the total amount of all payments withheld
  - If the health plan implements the corrective action according to the approved plan but does not successfully correct the administrative services failure within the time frame approved in the action plan, the state agency shall withhold payment from the next capitation payment due the health plan according to the same provisions as stated above.

Remedies for Failure to Comply with Marketing Requirements: **I**n the event the state agency determines that the health plan has failed to comply with any of the marketing requirements of the contract, one or more of the remedial actions listed below shall apply. The state agency shall notify the health plan in writing of the determination of the non-compliance, of the action(s) that must be taken, and of any other conditions related thereto such as the length of time the remedial actions shall continue and of the corrective actions that the health plan must perform.

The state agency shall require the health plan to recall the previously authorized marketing materials.

- The state agency shall suspend enrollment of new members to the health plan.
- The state agency shall deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the health plan and shall continue to deduct such payment until correction of the failure.
- The state agency shall require the health plan to contact each member who enrolled during the period while the health plan was out of compliance, in order to explain the nature of the non-compliance and inform the member of his or her right to transfer to another health plan.

- The state agency shall prohibit future marketing activities by the health plan for an amount of time specified by the state agency.

Intermediate Sanctions: The state agency may establish and specify intermediate sanctions that may be imposed when a health plan acts or fails to act as specified below. The state agency may require a corrective action plan, as referenced in section 2.29.4, to be developed and approved by the state agency in situations where intermediate sanctions may be imposed. The state agency shall approve and monitor implementation of such a plan and set appropriate timelines to bring activities of the health plan into compliance with state and federal regulations. The state agency may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, the state agency shall give the health plan timely written notice that explains the basis and nature of the sanction and any other due process protections that the state agency elects to provide.

- Fails substantially to provide medically necessary services that the health plan is required to provide, under law or under the contract, to a member covered under the contract.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the MO HealthNet program.
- Acts to discriminate among members on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the state agency.
- Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.
- Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.
- Violates any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations.

Types of Intermediate Sanctions: The types of intermediate sanctions that the state agency may impose upon the health plan include:
Civil monetary penalties in the following specified amounts:

- A maximum of $25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
- A maximum of $100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or the state agency.
- A maximum of $15,000 for each member the state agency determines was discriminated against based on the member's health status or need for services (subject to the $100,000 limit above).

- A maximum of $25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the MO HealthNet program. The state agency shall return the amount of overcharge to the affected member(s).

Appointment of temporary management for a health plan as provided in 42 CFR 438.706.
- Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
- Suspension of all new enrollments, including default enrollment, after the effective date of the sanction.
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the state agency is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

C. Health Information Technology

The MCO is required to adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, and RSMo 376.383 and 376.384.

In accordance with 42 CFR 438.242, the MCO is required to have a Claims Processing and Management Information System (MIS) capable of:
- Meeting the Managed Care Program requirements and maintaining satisfactory performance throughout the life of the contract.
- Transmitting and receiving data,
- Supporting provider payments,
- Compiling data reporting requirements
- Processing claims,
- Retrieving and integrating enrollment data,
- Assigning primary care providers,
- Maintaining provider network data, and
- Submitting encounter data.

The Claims Processing and MIS should be of sufficient capacity to expand as needed due to member enrollment or program changes. The MCO shall employ or have available, the resources necessary to make modifications to claims processing edits or expansion of MIS capabilities as a result of changes in Managed Care policies and/or procedures. The state agency will make every effort to give the MCO sixty (60) calendar days notice of changes in the Managed Care Program that may require the MCO to make system changes in order to comply.

The MCO shall have in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent

forms, certification for medical necessity for abortion, necessary operative reports, etc.). As part of this ECM function, the MCO shall also provide on-line and phone-based capabilities to obtain claims processing status information and support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

CyberAccess[SM]:

Also in 2006, a contract with ACS Heritage for a Clinical Management Services and System for Pharmacy Claims and Prior Authorization (CMSP) was signed and is in effect until 6/30/2012. The contract includes the operation of an innovative electronic web-based clinical editing process for point-of-sale pharmacy and medical claims, medical and drug prior authorization, and Drug Utilization Review (DUR) processes.

The CMSP claim processing system allows each claim to be referenced against the recipient's claims history including pharmacy, medical (ICD-9 codes), and procedural data (CPT codes) transparently. For those patients that meet any of the approval criteria, the claim will be paid automatically. In instances when a phone call is necessary, the hotline call center is available seven days a week, which allows providers prompt access to a paid claim for the requested product. In addition to receiving messages regarding the outcome of the processing of claims and the amount to be reimbursed, pharmacy providers receive prospective drug use review alert messages for their information at the time the prescriptions are dispensed.

The system provides and uses CyberAccess[SM]. CyberAccess[SM] provides: (1) participant claims history profiles, updated daily, identifying all drugs, procedures, related diagnoses and ordering providers from claims paid by MHD for a rolling 36 month period; (2) three years Point Of Service (POS) pharmacy claims with refresh every ten (10) minutes, and (3) access to Medicaid eligibility for all participants residing in the Northwest region.

CyberAccess now displays certain clinical data, and will soon expand to include electronic requests and assessments for home and community based services, inpatient hospital certifications, medication therapy management by pharmacies, access to on-line Early Periodic Screening Diagnostic Treatment (EPSDT) screening forms, and a web portal for participant health information.

Information Systems Availability

The MCO shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to ECM and self-service customer service functions are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the state agency and the MCO. The MCO shall ensure that at a minimum all other system functions and information is available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. Unavailability caused by events outside of a MCO's span of control is outside of the scope of this requirement. In the event of a declared major failure or disaster, the MCO core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.

Executive Order 07-12

In accordance with Executive Order 07-12, signed by the Governor of the State of Missouri on March 2, 2007, the health plan shall:

- Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect member privacy as required by law;
- Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services;
- Support making information available regarding the prices for procedures or services under the program; and
- Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed MCOs and reimbursement methods that reward providers for results.

The MCO shall provide the state agency with information concerning uniform utilization, quality assessment and improvement, member satisfaction, complaint, grievance, and appeal, and fraud and abuse detection data on a regular basis. On a periodic basis, the MCO shall make available clinical outcome data in areas of concern to the state agency. The MCO shall cooperate with the state agency in carrying out data validation steps. The state agency provides report formats and variable definitions for the MCO to use in reporting operational data. Data elements and reporting requirements are outlined in the MCO contract.

III. Improvement and Interventions

A. Interventions

Interventions for improvement of quality activities is determined based upon review and analysis of results of each activity and ongoing assessment of the participants' health care needs.

Automatic Assignment into MCOs

The state agency employs an algorithm to assign to the MCO, on a prorated basis, any Managed Care eligibles that do not make a voluntary selection of an MCO during open enrollment. The algorithm is based on the following:

- If the Managed Care eligible's case head is enrolled with a MCO, the Managed Care eligible shall be assigned to that MCO. If not, the next step in the algorithm will be followed.
- If the Managed Care eligible is included in a MO HealthNet eligibility case where another member is enrolled with a MCO, the Managed Care eligible shall be assigned to that MCO. If not, the Managed Care eligible will be assigned randomly.

During the first year of the contract, the MCOs share equally forty percent (40%) of the random auto assignments within each region. The remaining sixty percent (60%) of the random auto assignments in each region is based on the total performance score for each

MCO for that region. The performance score for each region is calculated on the following measures:

- The total evaluation score determined by the State of Missouri
- The MCO's Missouri regional score on the yearly HEDIS measure of annual dental visits;
- The MCO's Missouri regional score on the yearly HEDIS measure of adolescent well care visits;
- The MCO's Missouri regional score on the yearly HEDIS measure of mental health utilization;
- The number of FQHCs, RHCs, and CMHCs the MCO has in its network (beyond the minimum of one (1) in the region); and
- The inclusion of an acute care safety net hospital, (as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended) in its network.

The MCO receives a total number of points based on these six (6) measures; the total of these points is the performance score earned by the MCO. The performance score translates into a percent of the performance auto assignment. For the first year of the contract, MCOs that are new to the Managed Care Program or new to a region will receive the average score of all MCOs in the awarded region for its proxy HEDIS measures.

Each year of the contract, the state agency will change the performance measures included; recalculate the performance score and the performance auto assignment for each MCO.

In the second year of the contract, there will be a measurement of Emergency Department Visits which is a component of Ambulatory Care, an additional HEDIS measure, and the total evaluation score will be replaced by a measure based upon encounter data and the extent to which it matches with MCO financial data submissions.

In the third year of the contract, there will be one (1) additional HEDIS measure (for a total of six (6) HEDIS measures) and the total evaluation score will again be replaced by a measure based upon encounter data and the extent to which it matches with MCO financial data submissions.

The state agency will conduct meetings with stakeholders and the MCOs to solicit input on appropriate measures to be used during the second and third years of the contract. The state agency will inform the MCOs of the measures to be used at least six (6) months prior to the implementation of the changed performance auto assignment algorithm.

Performance Based on HCY/EPSDT Participant Ratio

In accordance with CMS guidelines, the state agency requires eighty percent (80%) of eligible members to have HCY/EPSDT well child visits and, accordingly, has included an eighty percent (80%) participant ratio in the rates paid to the MCO. In accordance with CMS 416 reporting methodology, the state agency shall measure MCO's performance regarding the percentage of eligible members having HCY/EPSDT well child visits (participant ratio). The state agency applies state specific criteria to the CMS

methodology to reflect the Managed Care Program. The state specific criteria reflects performance by Category of Aid and rate cell, the measurement schedule, and recognition of a month to be greater than twenty-seven (27) days. The participant ratio is defined as the number of total eligibles receiving at least one initial or periodic well child visit divided by the number of total eligibles who should receive at least one initial or periodic well child visit.

In the event that the HCY/EPSDT participant ratio is not equal to eighty percent (80%) of eligible members having an HCY/EPSDT well child visit as calculated using the HCFA 416 reporting methodology, the state agency shall with five (5) calendar days prior notice make a pro rata adjustment to the monthly capitation payment to the health plan for each percentage point above or below eighty percent (80%), but not to exceed one hundred percent (100%). This pro rata adjustment shall be based on the portion of the monthly capitation payment related to HCY/EPSDT well child visits and shall be applied to each rate cell in which well child visits are required.

If the MCO is new to a Managed Care region, the MCO shall agree that its capitation rate for the first contract year shall reflect the average participant ratio of the MCOs that are not new to the region by rate cell and category of assistance for the applicable measurement period. After the first contract year, the MCO's future capitation rate is adjusted by the MCO's actual 12-month HCY/EPSDT participant ratio.

Substance Abuse Treatment Referral Protocol for Pregnant Women under Managed Care

In 2006, the State and Department of Mental Health (DMH) developed a protocol to facilitate referral of pregnant women in Managed Care in need of substance abuse treatment to Comprehensive Substance Abuse Treatment and Rehabilitation Program (CSTAR). The protocol guides collaboration between the primary care provider (PCP), CSTAR provider, MCO case manager and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services.

During state fiscal year 2009, the DMH Division of Alcohol and Drug Abuse and MHD continued utilization of the protocol to facilitate referrals of pregnant women in managed care in need of substance abuse treatment to Comprehensive Substance Abuse Treatment and Rehabilitation Program (CSTAR), particularly to the specialized Women and Children CSTARs. The protocol guides collaboration between the primary care providers, CSTAR providers, health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services.

The protocol facilitates communication between stakeholders by providing geographic locations and contact information for CSTAR treatment programs and health plans. A multi-party consent to release information form is included in the protocol to document the pregnant women's informed consent for appropriate sharing of information between referring and treating entities. CSTAR providers are required to communicate sentinel treatment events to primary care providers and health plan case managers. CSTAR

providers are also required to involve primary care providers and health plan case managers in the pregnant women's continuing care plans. The Division of Alcohol and Drug Abuse Clinical Utilization Review Unit will monitor referral to CSTAR treatment programs through the protocol and ensure appropriate communication between the primary care providers and health plan case managers. The Division of Alcohol and Drug Abuse Clinical Utilization Review Unit submits quarterly reports to the MHD that track referrals and follow-up communication activities and issues for review.

Behavioral Health-Executive Order 98-12

Executive Order 98-12 requires the Department of Social Services (DSS) and the Department of Mental Health (DMH) to report to the Governor on their collaboration on behavioral health matters, including activities related to managed care. DSS and DMH enjoy a positive working relationship and continue to work collaboratively on a number of projects to improve behavioral health services for Missourians. This positive working relationship is making a difference to the people the departments mutually serve. The report is available upon request. For managed care behavioral health, outcomes have improved from the inception of the collaboration and during the last year. Variations in inpatient admissions have been experienced during the course of the collaboration. Data does not suggest a definitive cause, but the increase in admissions in 2008 continues a negative trend. Inpatient days have similarly varied over time and increased in the past year. Managed care behavioral health readmission rates have improved in the most recent year. This successfully reverses the prior negative trend.

Managed Care Indicators	**Movement Since EO 98-12** (Change 1999 to 2008 unless noted)	**Movement from Prior Year** (Change 2007 to 2008)
Mental Health Penetration Rates	+	+
➢ Ages 0-12 Years	+	+
➢ Ages 13-17 Years	+	+
Mental Health Inpatient Admissions Per 1,000	--	--
Mental Health Inpatient Days Per 1,000	--	--
Mental Health Outpatient Visits Per 1,000	+	+
Mental Health Ambulatory 7-Day Follow Up After	+	+
Mental Health Ambulatory 30-Day Follow Up After	+	+
Mental Health Inpatient Readmission Rate	-- (Note: 2004 to 2008)	+
+ **Positive** = **Unchanged** -- **Negative**		

Statewide Performance Improvement Projects (PIP)-Adolescent-Well Care

In the autumn of 2006, the State, the External Quality Review Organization (EQRO), and the MCOs collaborated to implement a statewide PIP focused on increasing the percentage of individuals age 12 to 21 who receives an annual Adolescent Well-Care (AWC) visit. All MCOs participated in the statewide PIP to educate members and support health care providers in optimizing health outcomes for Managed Care members.

The AWC goal set by the MCOs was for the statewide average score to exceed the NCQA national Medicaid mean for the comparable reporting year.

The original interventions were consistent across all MCOs beginning in 2007. An educational flyer was developed for providers to disseminate to the members they served. It provided education on the importance of well care and immunization, as well as ensuring members that transportation was available. Posters were developed with similar content, and distributed to providers to educate and to increase awareness for office staff and members.

It was decided to initiate a new methodology for the 2008 continuation of the PIP process. Each MCO developed individualized interventions. The MCOs reflected that they were aware of the needs of their members, the regional differences existed, and that they were uniquely qualified to develop interventions that best suited their members. The PIP Team was to continue to meet quarterly to share interventions, outcomes and lessons learned. Each individual MCO was responsible for conducting a root cause /barrier analysis of the 2007 intervention, and the incorporation of this information into future individual interventions.

During 2008 the State and the MCOs continued their collaborative effort on the statewide non-clinical Adolescent Well Care PIP. The MCOs identified this issue as one that could be defined as a common focus. The study topic documentation related that in addition to improving the outcomes of care for adolescents, improving the rate of well care screenings will improve the rate of adolescent preventive services available to the members, which is also an outcome desired by the State.

The basis for this PIP is well-developed and founded on a health care issue common to all MCOs. The MCOs utilized the study as a foundation to implement their own interventions. This project was not only an attempt to impact their HEDIS rates, but also to improve the provision of preventive health services to their members. The MCOs remain committed to this collaborative project. This effort has informed the MCOs and the State about their ability to recognize common health care issues, implement coordinated initiatives, and utilize individual interventions to improve services to all Managed Care members.

During January 2010 QA&I Advisory Group meeting, it was decided to replace the AWC state-wide PIP with an oral health state-wide PIP. Ongoing monitoring of the effectiveness of the AWC initiatives by the State and MCOs continues. The HEDIS AWC measure is used as a component of the auto assignment performance score for each MCO during the life of the current contract.

B. Interventions under Development

Behavioral Health Measures

As a result of the Behavioral Health reviews the QA&I Advisory Group reconvened the Behavioral Health Task Force to address problems identified. The Behavioral Health Task Force formed the following work groups:

- Psychiatric Access,
- Dashboard, and
- Case Management.

The work groups were comprised of MHD, DMH, MCO, Ombudsmen, and Behavioral Health Organization staff and charged with identifying behavioral health dashboard metrics to be reported to the State on a quarterly and/or annual basis. The behavioral health measures for which initial data is being collected includes the following:

- Increase by 2% annually the Follow-up After Hospitalization For Mental Health Disorders until benchmark goal (NCQA Quality Compass 50th percentile) is reached*;
- Increase the overall behavioral health penetration by 2 % annually*;
- Increase behavioral health outpatient visits by 2% annually;
- Increase by 2% annually members having access to behavioral health practitioners and providers within the geographic distances specified in the Network Adequacy Standards until > 90 percent have access to services;
- Increase the number of participants who self select a Primary Care Provider by 5% annually;
- Increase by 2% annually the number of behavioral health providers (Psychiatrists, Psychologists, and all other behavioral health providers)/1000 members statewide and regionally;
- Increase by 2% annually the full time equivalent (FTE) of behavioral health providers (Psychiatrists, Psychologists, and all other behavioral health providers)/1000 statewide and regionally;
- Increase by 2% annually the number psychiatrists with open panels for children $\leq$ 6 years old, children 7-12 years old, adolescents (13-17 years old), and adults ($\geq$ 18 years old) to 70% open panels;
- Increase by 2% annually psychiatrist appointment availability for children $\leq$ 6 years old, children 7-12 years old, adolescents (13-17 years old), and adults ($\geq$ 18 years old) until 85% or more of psychiatric practices treating children will have routine appointments available within 10 business days (NCQA standard);
- Increase by 2% annually psychiatrist overall appointment availability until 85% or more of psychiatrist practices will have appointments available to meet NCQA QI 5 Element B; a) Emergent (non-life threatening)-within 6 hours; b) Urgent-within 48 hours; c)Routine-within 10 business days.
- Decrease behavioral health Emergency Room visits by 2% until meet NCQA Quality Compass between the 25th-75th percentile;
- Decrease behavioral health inpatient days by 2% annually;
- Decrease behavioral health substance abuse days by 2% annually;
- Decrease inpatient behavioral health discharges by 2% annually;
- Decrease substance abuse discharges by 2% annually.

State Wide Oral Health Performance Improvement Project

Access to dental services is an ongoing nationwide challenge for many health plans that serve the Medicaid population. More than half of the children on Medicaid received no dental service in 2007. During this same time period in Missouri, the rate of dental service utilization was 27.9%. Underutilization of dental services is not a problem

specific to the Medicaid population. Nationwide only 58% of children with private insurance receive dental care.

Based on a 2008 site visit at the Department of Social Services/MO HealthNet Division conducted by the Center for Medicaid & Medicare Services (CMS) and subsequent site visit report, it was determined that a statewide Performance Improvement Plan (PIP) for dental screening needed to be initiated. The MCOs are collaborating to improve dental care in the MO HealthNet population. Some of the following recommendations discussed by the Dental Task force include:

- Provide a separate dental handbook for beneficiaries written in appropriate language styles.
- Notify beneficiaries of the contractual time frame for appointment in conjunction of their right for adverse action if they fail to obtain a appointment
- Develop a standard for the timely provision of services within the guideline developed in the State Medicaid Manual and ensure those standards are carried out
- Evaluate each dental benefit administrator network based on the number of total Medicaid beneficiaries in the service area being covered
- Consider reimbursing provider for more frequent application of fluoride varnish for high-risk children
- Incorporate better care coordination and case management to integrate EPSDT service and receipt of dental care
- Consider an outreach program or statewide Performance Improvement Project (PIP) to improve oral health for children and for prenatal or perinatal mothers
- Ensure a dental home for children in Missouri
- Document the oral health needs of special need children and the adequacy of dental specialist in both rural and urban areas.

The MCOs collaborating in this project provide comprehensive dental care as a part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. All dental services are covered, including diagnostic care, as well as all necessary treatment and follow-up care with no limits on services or costs. Dental benefits are covered for all members from birth through age twenty (20) and for all pregnant women. Non-pregnant members who are twenty-one (21) or older do not have any dental benefits unless there are chronic conditions related to oral health (i.e. cancer, trauma related to oral health, diabetes, etc.).

The success of the project will be evaluated by demonstrating an increase in the Annual Dental Visit total HEDIS rate for the MCOs combined. The MCOs generated a numerator and denominator for the measure based upon the HEDIS Technical Specifications. As required by the Managed Care contract, the calculation of the rate is audited by a certified HEDIS auditor. The MCOs report their rate by June 15th of each year. Annual Dental Visit HEDIS 2009 (2008 Measurement Year) rate serves as the baseline rate for the project. Comparisons will be made yearly to identify if there are any statistically significant increases in rates from the previous year and from the baseline.

National Committee for Quality Assurance (NCQA) Accreditation

Effective October 1, 2011, the Managed Care MCOs must be NCQA accredited, at a level of "accredited" or better, for the MO HealthNet product. The MCOs must maintain such accreditation thereafter and throughout the duration of the contract. The State of Missouri will require all future Managed Care contractors to be NCQA accredited.

IV. Strategy Effectiveness

The quality strategy is reviewed on an annual basis by MO HealthNet Division and MCO quality staff through an ongoing process that incorporates input from a multitude of sources. The effectiveness of the quality strategy is revised based upon analysis results, as necessary. The quality strategy may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. Following approval by the QA&I Advisory Group, the quality strategy is sent to CMS for approval.

A. External Quality Review (EQR) Report

The EQR report provides detailed information regarding regulatory compliance of MCOs as well as results of Performance Improvement Projects (PIPs), Performance Measures (PMs), and results of encounter data validation. Report results provide information regarding the effectiveness of the MCOs' QA&I Program, identifies strengths and weaknesses, and provides recommendations for improvement. This information is utilized for input into the QIS and for initiating and developing a statewide PIP.

B. MCO Reporting Requirements

The following reporting periods have been defined for reporting of monthly, quarterly and annual reports by Managed Care health plans participating in the Managed Care Program.

MONTHLY REPORTING	
Time Period	**Due Date**
Calendar month	Last working day of the month
QUARTERLY REPORTING	
Time Period	**Due Date**
1st Quarter (July thru September)	December 1st of each year*
2nd Quarter (October thru December)	March 1st of each year*
3rd Quarter (January thru March)	June 1st of each year*
4th Quarter (April thru June)	September 1st of each year*
ANNUAL REPORTS – ANNUAL EVALUATION, MULTILINGUAL SERVICES, SUBCONTRACTOR OVERSIGHT	
Time Period	**Due Date**
January 1 thru December 31	April 30 of each year*
HEDIS MEASURES	
Time Period	**Due Date**
January 1 thru December 31	June 30 of each year*

*If the due date falls on Saturday or Sunday, the reports are due on the last working day of the prior month.

The frequency and types of reports include:

- Monthly Reports: Monthly reports of members with special health care needs and elevated blood lead level are submitted to the state agency.
- Quarterly Reports: Quarterly reports of member grievances and appeals; provider complaints and appeals; and fraud and abuse activities are submitted to the state agency.
- Annual Evaluation: An annual evaluation of the MCOs' Quality Assessment and Improvement Program, specific to the Missouri's Managed Care Program, is submitted to the state agency.

The Annual Evaluation shall contain information:

- Concerning the effectiveness and impact of the MCOs' QI Strategy;
- Indicating data is collected, analyzed, and reported;
- That health operations are in compliance with State, Federal and Managed Care contractual requirements;
- Showing multiple year outcomes and trends; and

- Demonstrating the QA&I Program is ongoing, continuous and based upon evaluation of past outcomes.

Periodic Reports of Quality and Utilization:

- The MCOs will provide periodic reports regarding case management, quality initiatives, and other quality analysis reports per MO HealthNet MHD request.
- An annual report regarding multilingual services for members who speak a language other than English and the MCOs methods for communicating with members with visual and hearing impairments and accommodating for the physically disabled.
- Annual subcontractor oversight reports that reflect the MCOs monitoring activities in the previous year for each health care service subcontractor and any corrective actions implemented as a result of its monitoring activities. The annual subcontractor oversight reports shall be submitted in the format specified by the state agency.

V. Achievements and Opportunities

A. MO HealthNet QA&I Advisory Group

The MO HealthNet QA&I Advisory Group continues to exhibit a well-attended, well-balanced process of communication of State/Federal quality program expectations and interventions. Meetings are open to additional stakeholders on a meeting agenda-driven basis. Consistent participation by the External Quality Review Organization (EQRO) has facilitated a more efficient and effective process of identifying quality program opportunities, recommendations for improvement and active engagement of the health plans in responding to audit findings to reduce past historical backlogs across fiscal years. The QA&I tracking log continues to be an important and positive tool for keeping all partners focused on critical improvement initiatives as guided by the State and CMS and implementing quality strategies.

B. HEDIS and Behavioral Health Measures

Through the QA&I Advisory Group the MO HealthNet Division, MCOs, and other stakeholders will continue to monitor and evaluate for improvement the HEDIS measures and behavioral health measures. The positive trends and opportunities for improvement are noted below.

HEDIS Positive Trends:

- Adolescent Well-Care Visits
- Annual Dental Visit: Age 2-3
- Annual Dental Visit: Age 4-7
- Annual Dental Visit Age 7-10
- Annual Dental Visit Age 11 – 14
- Annual Dental Visit Age 15 – 18
- Annual Dental Visit Age 19 – 21
- Annual Dental Visit Combined Rate
- Asthma Ages 5 – 9
- Asthma Age 10 – 17

- Asthma Age 18 – 56
- Asthma Combined
- Chlamydia Screening Age 16 – 20
- Chlamydia Screening Combined Rate
- Well Child Visits in the First 15 Months of Life: 1 Visit
- Well Child Visits in the First 15 Months of Life: 2 Visits
- Well Child Visits in the First 15 Months of Life: 3 Visits
- Well Child Visits in the First 15 Months of Life: 4 Visits
- Well Child Visits in the Third through Sixth Year of Life
- Postpartum Care
- Timeliness of Prenatal Care
- Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge

HEDIS Opportunities for Improvement

- Cervical Cancer Screening
- Childhood Immunization
- Chlamydia Screening Ages 21 – 26
- Well Child Visits in the First 15 Months of Life: 0 Visits
- Well Child Visits in the First 15 Months of Life: 5 Visits
- Well Child Visits in the First 15 Months of Life: 6+ Visits
- Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge

Behavioral Health Positive Trends

- Consistent annual increase in penetration rate
  - 47.5% increase among the 0-12 year age category
  - 82% increase among the 13-17 year age category
- Outpatient visits per 1000 increased
  - 85% between 1999 and 2007
  - 4% increase between 2006 and 2007
- Variability in ambulatory follow up
  - After discharge 7-day indicator in 2007 was 35.6%, double that of 1999
  - Reported follow up has generally increased since 1999
- Ambulatory follow up 7-day
  - 35.6% after discharge (double that of 1999)
  - General increase in reported follow-up since 1999
- Ambulatory follow up 30-day
  - Performance indicator was equal to or greater than the national mean from 2001 - 2007
  - 28% increase since 1999

Behavioral Health Opportunities for Improvement

- Increase in inpatient admissions per 1000
  - 13.2% increase between 2001 and 2007
- Increase in inpatient days per 1000
  - 1.6% increase from 2006 to 2007
- Inpatient readmission rate
  - 21.4% increase since 2004

- Readmission rate
  - 18.1% increase for 2007 over 2006

Behavioral Health Other Opportunities for Improvement

- Improve customer service workflow and outreach,
- Improve consistency of application of LOCUS and CAL/LOCUS,
- Identify and implement best practices in service delivery for the Medicaid population,
- Assure discharge planning begins at admission, and
- Assure Behavioral Health Medical Director has direct line authority over and meaningful involvement in clinical operations, including accountability for monitoring over and under utilization.

C. Partnerships with Other State Agencies

A major area of strength has been the ongoing partnerships with the Department of Mental Health to improve health outcomes for those accessing behavioral health services and with the Department of Health and Senior Services to improve the health outcomes for the Maternal and Child population.

Substance Abuse Treatment Referral Protocol for Pregnant Women under MO HealthNet Managed Care: There are continued efforts to enhance the quality of communication between treatment providers and the managed care plans to ensure effective coordination of care. Providers are encouraged to be persistent in efforts to determine MO HealthNet eligibility throughout an episode of care.

Behavioral Health Reviews of the MCOs Behavioral Health Subcontractors: MHD and DMH staff work together to perform the annual evaluation of the MCOs behavioral health subcontractor's operations regarding quality and utilization management. These reviews have proven to be valuable in determining opportunities for improvement.

Maternal Child Health Task Force: Through a collaborative process with the Department of Health and Senior Services (DHSS), the MO HealthNet Division (MHD), and the MCOs, the measures collected and reported on the Trends Report were revised to be updated to collect more meaningful information. The revisions to the Trends Report included pre-pregnancy BMI was to be noted (when >30), gestational age was added (<32, 32-36 weeks), and asthma emergency room visits was broken into age categories (0-3 and 4-17, and 18-64). Also the changes include deleting reports of fetal death, repeat C-section, and not dividing hysterectomies into abdominal and vaginal.

Maternal Child Health Action Learning Collaborative: Missouri has been invited, along with Ohio and West Virginia, to participate in an Action Learning Collaborative sponsored by the Association of Maternal and Child Health Programs and the National Association of Chronic Disease Directors. The focus of this Collaborative is on gestational diabetes mellitus and its relationship to the future onset of Type 2 Diabetes. The purpose of the Collaborative is to assist states in developing an action plan and strategies to address this issue.

Missouri's vision for this Collaborative is that the maternal and child health and chronic disease program staff and their partners will systematically plan for and collaborate on program activities, based on a thorough understanding of cross-program issues and data. This Collaborative is designed to last approximately 18 months but may continue beyond that depending on progress made and action items that are remaining

The Department of Health and Senior Services, MO HealthNet Division, and the MCOs have joined together to work on this Collaboration.

D. State-Wide Performance Improvement Projects (PIP)

Additionally, the State-Wide Performance Improvement Projects have brought various stakeholders together as partners for the improvement of Adolescent Well-Care and Oral Health. The Adolescent Well-Care PIP was validated by the EQRO to ensure compliance with CMS regulation.

Adolescent Well-Care Visits PIP: This PIP has been formally replaced by the Oral PIP, but the MCOs continue to evaluate the effectiveness of their initiatives and the measure continues to be monitored by the individual MCOs as they track adolescent well care rates. MCO specific interventions continue to be completed on an annual basis to increase adolescent well care rates. The MCOs' regional score for Adolescent Well-Care Visits is used in the Auto-Assignment Process.

Oral Health PIP: Based on a 2008 site visit to the Department of Social Services/MO HealthNet Division conducted by CMS, it was determined that a statewide Performance Improvement (PIP) for dental screening needed to be initiated. The stakeholders participating in this PIP include MCOs, MHD, Ombudsman, and MCO dental subcontractors.

E. Other Quality Improvement Initiatives

NCQA accreditation and Automatic Assignment into MCOs are two MO HealthNet quality initiatives which provide very specific guidelines to the MCOs for quality improvement.

F. MCO Best Practices

The 2009 EQRO Review Report identified the presence of MCO best practices. Those best practices are noted below.

Blue-Advantage Plus of Kansas City-Immunization Initiative: This initiative provides education to members regarding the need for regular check-ups and the importance of obtaining required immunizations.

Children's Mercy Family Health Partners-Wellness and Prevention: This project synchronized the distribution of information to members in coordination with local and national recognition months for health screenings and disease management awareness.

Harmony Health Plan-Pay for Quality Program: This project focused on improving access to care and the delivery of quality services to members by rewarding providers

when their individual statistics reflected their efforts to assist in improving member education and other preventive services.

HealthCare USA-Cultural Competency Program: This program strives to ensure that members receive appropriate care in a culturally-sensitive environment, and further ensures that health plan staff focus on cultural competency at all levels.

Missouri Care Health Plan-"I CAN…Help My Child Stay Healthy" Project: The Health Plan partnered with the Central Missouri Community Action Center ensure that all eligible children in the region were enrolled in Head Start, and that all children in Head Start obtain all preventive health care available. The goals of the partnership include decreased Emergency Room visits and improved parent health literacy.

Molina Health Care of Missouri-Case Management for Pregnant Women: **B**eginning **A**nother **B**eautiful **Y**ou through **C**oordination of care, **A**ssessment, **R**eferral and **E**ducation (B.A.B.Y. C.A.R.E.) has been implemented to improve obstetrical outcomes, reduce obstetrical-related hospital admissions and decrease the incidence of pre-term deliveries by identifying, educating and managing members with risk factors throughout their pregnancy.

VI. Conclusion

The MO HealthNet Division maintains a collaborative process to collegially work with the MCOs and other stakeholders to improve care. Goals, objectives, strategies, and initiatives identified throughout this document have been implemented with an emphasis on ensuring quality health care services are provided to the Managed Care members and that the MCOs are in compliance with Federal, State, and contract requirements

The MO HealthNet Division is focused on continuous quality improvement through the collaboration with its partners and stakeholders supporting the mission of the Department of Social Services (DSS) to maintain or improve the quality of life for the people in the State of Missouri by providing the best possible services to the public, with respect, responsiveness, and accountability which will enable individuals and families to better fulfill their potential.